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ABSTRACT

This document presents a review of recent research literature on eight components in a system of care for children with serious emotional disturbances. It is intended to be a guide and source of information to communities for building systems of care. Components include: residential services (psychiatric hospitals and residential treatment centers), outpatient services (psychotherapy), day treatment services, family preservation services, therapeutic foster care, crisis and emergency services, case management/individualized care, and family support services. The review of each component consists of definitions, summaries of outcome and empirically based efficacy studies, cost-effectiveness data, and (for most components) research needs. Generally, only studies published since 1988 were included. (Each chapter contains references.) (JDD)

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Components of a System of Care

WHAT DOES THE RESEARCH SAY?

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Introduction

During the past decade, a number of changes have occurred in the way we serve children with serious emotional disturbances and their families. This period of transition has been described as involving a shift in both conceptualization and practice (Duchnowski & Kutash, 1993; Knitzer, 1993). Knitzer (1993) described four shifts as relating to families, intensity of services, cultural sensitivity, and the development of community-based systems of care. The first shift involves a new conceptualization of the role of the family. Traditionally, families have been viewed as the "cause" of the problems experienced by their children. However, over the past decade, active efforts to eliminate this stereotype and attempts to have families participate more fully in the treatment planning process for their children have begun. A second shift involves a transformation in the conceptualization of service intensity. Until recently, intensive services were thought to be possible only by placing children in secure residential settings away from their parents and community. Currently, the development of new services, such as family preservation and individualized, wrap-around services, has

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allowed children to receive intensive services in a natural setting. The third shift pertains to the development of culturally competent service delivery systems. The development of culturally sensitive services requires an acknowledgment of cultural differences as well as the formulation of services which meet the needs of families of color. The fourth shift is concerned with the building of community-based systems of care. The system of care model proposed by Stroul and Friedman (1986, 1994) is based on the belief that services are to be provided in the least restrictive setting that is appropriate to the needs of the child and family. A comprehensive and coordinated array of services ranging from residential to nonresidential settings must be in place to successfully meet the individual needs of the child and family. The model presents a framework comprised of seven major dimensions of service—mental health, social, educational, health, vocational, recreational, and operational—each representing an area of need for children and families. Within each of the service dimensions is an array of service components which serve as building blocks within the system of care. For example, the mental health dimension consists of both nonresidential (e.g., outpatient services, day treatment) and residential services (e.g., therapeutic foster care, inpatient hospitalization).

It is noteworthy that Stroul and Friedman (1986, 1994) have given research an important role in the development of their system of care model. This model is "designed to be a guide, based on the best available empirical data and clinical experience to date. It is offered as a starting point . . . as a baseline from which changes can be made as additional research, experience and innovation dictate" (p. 29). Burns and Friedman (1990) described two levels at which the effectiveness of a system of care for children and adolescents can be investigated. The first level of research entails the more traditional program evaluation strategies of examining and describing the feasibility, acceptability, and general usefulness of an intervention. Models, challenges, and designs for this level of research have been published and disseminated (see Bickman, 1992; Kutash, Duchnowski, Johnson, & Rugs, 1992; Stroul, 1993). The second level of research used to examine the efficacy of a program requires a controlled experiment in a natural setting. The present review provides an overview of the available literature using this latter type of research.

Burns and Friedman (1990) conducted a review of the research base for child mental health services and concluded that although there had been an expansion in research which examines children's mental health services, a considerable degree of additional research was needed. One part of the research agenda focused on the examination of the effectiveness of the components within a system of care. More recently, Burns (in press) again suggested that evaluation and research on the components within a system of care are essential building blocks within the system of care philosophy.

The purpose of this current investigation was to add to the literature review conducted by Burns and Friedman (1990) as well as to serve as a guide and source of information to communities for building systems of care. A review of recent research literature on eight components in a system of care for children was conducted and synthesized. These components included the following : residential, outpatient (psychotherapy), day treatment, family preservation, therapeutic foster care, crisis and emergency, case management/individualized care, and family support. The reviews consist of definitions of the components, summaries of outcome and empirically-based efficacy studies, and cost-effectiveness data. The sources searched included PsycLIT, ERIC, and Sociofile databases, monographs, and documents included in the conference proceedings of the Annual Research Conference on Children's Mental Health sponsored by the Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida, in Tampa. With some exceptions, only studies published since 1988 were reviewed. Articles and reports that are summaries of reviews and meta-analyses were included, and these reviews may reflect studies conducted prior to 1988.

Each chapter was reviewed by experts in their respective area of children's mental health, e.g., case management or day treatment. It is to these people that we owe our gratitude for their contribution of time and valuable insight into our endeavors. We would like to express our thanks to the following reviewers: Karen Blase, Barbara Burns, John Curry, Lucile Eber, Mary Evans, Glenda Fine, Steven Forness, Pam Meadowcroft, Janice Moore, Carole Pastore, Steven Pfieffer, Barbara Thomlison, John Weisz, Kathleen Wells, and Susan Yelton. Also, our gratitude is

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The dissemination of research results to parents, service providers, and policymakers in the field of children's mental health is an important part of research that is often overlooked. It is our hope that this review of the literature on the effectiveness of the components in a system of care may stimulate and guide future research endeavors that will ultimately lead to improved services for children with serious emotional disturbances and their families.

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Introduction

Residential Services:

Psychiatric Hospitals and Residential Treatment Centers

According to Stroul and Friedman (1986), a range of both residential and nonresidential services is necessary within the children's mental health service system. A variety of settings along the continuum of care have been established to meet the mental health needs of children and youth. At the most restrictive end of the continuum are residential services. For the purpose of the following review, research on both residential treatment centers and inpatient hospitalization is included.

Residential treatment centers (RTCs) serve as an alternative to psychiatric hospitalization. These 24-hour facilities, which are not licensed as hospitals, offer mental health services to children (Tuma, 1989). RTCs vary in degree of structure as some are highly structured, while others are similar to group homes or halfway houses. They also vary with regard to the range of services provided as some offer a full range of services, while others provide only custodial care.

Inpatient hospitalization is the most restrictive setting along the continuum of care (Tuma, 1989). During hospitalization, the child is removed from the home and the total care of the child is undertaken by hospital staff. This service is "reserved for extreme situations, for youngsters who are showing serious acute disturbances or particularly perplexing and difficult ongoing problems" (Stroul & Friedman, 1986, p. 59). Hospitals use an array of interventions, including individual, family, and group therapy; pharmacotherapy; milieu therapy; and behavioral modification. In addition to those listed above, Dalton, Muller, and Forman (1988) suggest that treatment planning, parent training, and daily school experiences also exist within the hospital setting.

Due to the recent movement toward the establishment of a continuum of care and the increasing concern about the number of children being placed in residential treatment (Wells, 1991), psychiatric hospitalization of children has been a focus of recent attention. This concern primarily has focused upon ensuring that only those youth who require a highly restrictive placement are placed in residential settings and that an array of alternative services are available to those children who can be adequately served in a less restrictive setting. Because some children do require a highly restrictive placement setting, residential treatment services remain an integral component of a comprehensive system of care for children with serious emotional disturbance (Allen & Leichtman, 1990; Singh, Landrum, Donatelli, Hampton, & Ellis, 1994).

Due to the varying methods used to place youth in residential settings, the number of children receiving such treatment for any given year is uncertain (Yelton, 1993). However, the Select Committee on Children, Youth, and Families (1990) reported that 25,334 children were in residential care in 1986, an increase of more than 30% over a three year period.

Zimmerman (1990), summarizing survey findings reported by NIMH, stated that rapid increases in the admission of adolescents to psychiatric hospitals have occurred across the nation. During 1980, over 81,000 youth under the age of 18 were admitted for inpatient psychiatric treatment and about 55,000 of these individuals fell into the age range of 15-17 years.

Based on data from 50 states, Zeigler-Dendy (1990) and Garrison (1990) reported the following summary findings of residential service use from the Invisible Children's Project: a total of 22,472 children and youth were placed in state hospitals with an average length of stay of about four months; a total of 4,098 children and youth were placed in out-of-state treatment facilities; and over 14,000 were served in residential treatment facilities within the state.

In a paper reviewing mental health service use by adolescents in the 1970s and 1980s, Burns (1991) reported 1986 cross sectional data for 10-18 year olds. The majority (69%) received outpatient services, while the more restrictive services, such as inpatient, residential treatment centers, and partial hospitalization facilities, served a smaller percentage. In addition, Burns conducted an investigation of service use over time (1975-1986) and found that both outpatient services and residential treatment centers had over a 60% increase in use in 1986 than in 1975. Thus, it appears that although estimates of the number of children receiving residential care vary, this component of care continues to serve a large number of children in need of mental health services.

Cost/Cost Estimates

As well as representing the most restrictive form of care for children, residential services also are the most expensive. Burns and Friedman (1990) state that psychiatric hospitalization often costs around $500 per day. With an average length of stay of approximately 30 days, this form of treatment can be expensive. Residential treatment centers also are an expensive form of treatment with costs ranging between $100 to $300 per day of care (Stroul & Friedman, 1986); however, when compared to the cost of hospitalization, this treatment approach is much less expensive.

The Invisible Children's Project (Garrison, 1990; Zeigler-Dendy 1990) was conducted as an effort to gather information on a national level regarding the number of children in residential placement settings as well as the cost of such placements. Costs estimated from the results of this project revealed an average per diem rate of about $112.00 for residential treatment programs. A total annual cost of over $200,000,000 was estimated for the 4,098 children reported in out-of-state residential placement, using cost data from the state of Indiana in the calculation. Based on detailed cost data from six states, the average daily rate for youth in state mental hospitals was about $300; thus, annual treatment costs per child would be $109,193. Based on these cost estimations, it was projected that on a national basis, treatment for the 22,472 youth in state hospitals with an average length of stay of 4.2 months would cost over $850,000,000. In a recent survey of financial practices, 42 of the 50 states reported the use of state hospitals as a placement for children and youth (Kutash, Rivera, Hall, & Friedman, in press). Thus, it appears that states continue to rely on the use of hospitalization which results in substantial cost to states.

Recent discussions on the financing of mental health services for children and youth have suggested that the establishment of a comprehensive continuum-of-care system would result in a dramatic reduction in the cost per child when costs are averaged for all children receiving services along the continuum (Behar, 1990). This point is further emphasized by the findings of a study conducted by Hoagwood and Cunningham (1992) in which cost estimates suggested that the implementation of a comprehensive array of services could reduce state residential and inpatient psychiatric hospitalization costs by 60 %. Promising results from the California AB377 Evaluation Project have begun to demonstrate that the implementation of a comprehensive system of care can result in overall cost savings (Attkisson, Dresser, & Rosenblatt, in press; Rosenblatt, Attkisson, & Fernandez, 1992). This project, which replicated the system of care for youth with severe emotional disturbances "pioneered" in Ventura County, has been implemented in three other California counties. Due to the high numbers of youth served in residential group homes and the subsequent cost of serving these youth, the project sought to reduce placements and costs by providing a coordinated and effective system of care. Results indicated that the demonstration counties, when compared to the state of California as a whole, reduced the number of group home placements and thus, expenditures. Similar results were obtained for the CHAMPUS Tidewater Demonstration Project (Burns, Thompson, & Goldman, 1992). This project was an attempt to reduce the use of more restrictive and costly residential services through the implementation of a partial hospitalization placement setting and a more effective monitoring system. Results revealed a shift in the use of levels of care with a greater number of children being admitted to the outpatient treatment setting over time, while admissions to inpatient treatment settings decreased over time. Thus, as the use of more costly inpatient treatment settings declined, the costs of mental health services decreased.

Despite the significantly higher cost of residential placement in comparison to other service types and the criticisms that have characterized it as an overused and unnecessarily restrictive placement setting, this component continues to be an integral part of a comprehensive system of care as it is a necessary placement for a portion of children and youth identified as seriously emotionally disturbed (Singh, Landrum, Donatelli, Hampton, & Ellis, 1994).

Effectiveness and Outcome Research

"Recent pressure from third party payors, as well as philosophical and theoretical changes within the field of mental health, have raised questions about the appropriateness of psychiatric hospitalization of children. Increased scrutiny has underscored the need for efficacy studies to determine the utility of this form of treatment" (Dalton, Muller, & Forman, 1988, p. 232). However, little research on outcomes and effectiveness is currently available (Stroul & Friedman, 1986; Burns & Friedman, 1990).

A number of scholarly reviews of the existing literature on the efficacy and outcome of residential treatment have been completed. Blotcky, Dimperio, and Gossett (1984) summarized the findings of 24 efficacy studies conducted between 1936 and 1982 which examined the outcome of children treated in psychiatric hospitals. The following factors were found to be predictive of a positive outcome: adequate intelligence, nonpsychotic and nonorganic diagnoses, absence of bizarre and antisocial behaviors, healthy family functioning, adequate length of stay, and adequate aftercare. Most of the studies suffered from serious methodological weaknesses; thus, findings should be viewed with caution.

Dalton, Muller, and Forman (1988) reviewed two outcome studies which measured the effectiveness of specific inpatient interventions in the treatment of children with conduct disorder and antisocial behavior. The first study (N = 26) found no significant change in behavior following three months of treatment on a psychiatric unit, although some gains in social relationships were noted. The second study (N = 40) examined the combined effects of parent management training and cognitive-behavioral problem-solving skills training for children with antisocial behaviors. Both at discharge and at one year follow-up, the group receiving the inpatient intervention exhibited significantly less aggressive and externalizing behaviors at home and at school than did the control group which received no treatment.

Chapter One

Burns and Friedman (1990) cited one clinical trial which compared the behavioral and educational outcomes of a group of children randomly assigned to hospitalization and community-based treatment services. Results revealed that outcomes at discharge were comparable for both groups. However, at follow-up, one-half of the hospitalized group and only one-fourth of the community-based group were in institutions. In an examination of the research base underlying the effectiveness of residential treatment centers, Burns and Friedman (1990) cited two studies which revealed no significant benefits resulting from residential treatment when compared to alternative methods, although follow-up studies on the effectiveness of RTCs generally report positive results. A third study revealed the effectiveness of a residential treatment center and found postdischarge support to be necessary for the maintenance of treatment gains.

Pfeiffer and Strzelecki (1990) provided a review of outcome studies on inpatient psychiatric and residential treatment of children and youth conducted from 1975 to 1990. It should be noted that none of the 34 follow-up studies in this review utilized random assignment of subjects (Bickman, 1992). A synthesis of the results of the 34 follow-up and outcome studies was conducted using a method developed by the authors. For a discussion of possible limitations of this technique, see Blotcky and Dimperio (1991). For each study, the relationship between outcome and a predictor variable was rated as negative, neutral, or positive; this value was then adjusted according to the sample size. Using this method, the following factors were found to be predictive of a positive outcome: the presence of a specialized treatment regimen, the availability of aftercare services, and less severe child and family dysfunction. Intelligence and length of stay were moderately predictive of a favorable outcome. Age and gender were found to be unrelated to outcome.

Cornsweet (1990) reviewed the findings of two controlled studies of inpatient treatment of preadolescent children. The first study involved children admitted to an inpatient unit and deemed appropriate for hospitalization. Children were randomly assigned to either hospital treatment (up to 6 months) or brief hospital-based evaluation followed by intensive community-based treatment. At discharge, the children were compared across various family, behavioral, and educational variables. Several methodological limitations exist with this study;

however, findings revealed that both groups improved on behavioral and educational variables, while family functioning remained constant. The second study compared the effectiveness of a cognitive-behavioral problem-solving skills approach to nondirective relationship therapy in the treatment of children with antisocial behaviors admitted to an inpatient unit. An attention-only control group received contact but no efforts were made to address problems or affective issues. Children were randomly assigned to one of the three groups. Discharge and follow-up results obtained at three points in time revealed greater behavioral gains for the group receiving problem-solving skills training when compared to the group receiving relationship therapy and the attention-only control group.

Curry (1991) provided yet another review of the available outcome research on the residential treatment of children and youth. In his review of studies using single-sample designs, Curry included both hospital-based and residential treatment-based studies. The results of the hospital-based studies suggested that outcomes vary. That is, while many children improve, others show no improvement and a small percentage may reveal "seriously negative outcomes" at follow-up. The importance of support and aftercare following discharge was emphasized. Curry then summarized the findings of three residential treatment-based studies. Briefly, the first study found that subjects' adaptation improved during treatment and that the majority (71%) were functioning adequately at follow-up. The second study revealed an association between adaptation following discharge and the child's perception of support and continuity. A third study demonstrated that while most of the children treated in the residential treatment center showed improvement during treatment, treatment gains were not predictive of later adjustment. Due to the nature of single-sample designs, these studies failed to address the question of effectiveness but did contribute to the existing knowledge base.

The results of four studies utilizing more powerful comparative designs were reviewed (Curry, 1991; see also Quay, 1986, for a review of these studies). The first study, Project Re-Ed, is an example of a between program study using treatment-no treatment groups. The treatment group received direct treatment from specially trained teachers, while also involving the child's family and school. Findings revealed that those receiving treatment fared better than those in the no-treatment group; however, only about 50% of the children received a change in their special education placement category of severely behaviorally impaired. The Close-Holton Study serves as an example of a between-program study using between-treatment groups. The Close School utilized a transactional analysis group approach, while the Holton School employed a behavioral modification treatment approach. This study did not reveal major differences in treatment effectiveness based on type of treatment approach. The Balderton Hospital Study, a within-program study using a between-treatment design, focused on the treatment of adolescents on probation using two types of alternative treatment approaches: a self-governing group therapy program and an authority-based program. At follow-up, those in the authority-based treatment group had committed fewer offenses than those in the self-governing group. The last study reviewed by Curry was the California Community Treatment Project, an example of an across-program study design. This study was designed to test whether those delinquents viewed as in need of residential services actually did better when they received it. Subjects deemed in need of residential services were randomly assigned to either residential treatment or community-based treatment. For those judged in need of residential care, results revealed a lower rate of rearrest for those receiving residential treatment than for those not receiving it.

A number of studies conducted from 1988 to the present and not included in the reviews above are described. Ney, Adam, Hanton, and Brindad (1988) conducted a one-year follow-up study to determine the effectiveness of a child psychiatric unit. The 10-bed facility provided treatment for the full range of children with psychiatric problems. The children ($N = 112$) involved in the study represented a variety of presenting problems, with the majority having a diagnosis of conduct disorder. Other diagnoses included encopresis, anorexia, major depression, psychomotor epilepsy, autism, fire setting, and various symptoms resulting from abuse and neglect.

Prior to hospitalization, children underwent a 2-week assessment process conducted in the home and school settings. Treatment plans were established on the first day of admission. The facility provided a five-week inpatient program and a five-week follow-up period. A combination of 65 treatment techniques developed on an individual basis for each child was implemented by staff. The children's friends and family were involved in the hospitalization process. Parents attended weekly seminars and were taught a variety of child management techniques.

Following inpatient treatment, changes in the functioning of parents and children involved in the study (N = 112) were assessed. The majority of parents indicated that they were more frequently able to talk and to listen to their child. At one year postdischarge, about 84% of the parents reported that the program was very helpful, 8% reported that treatment made no difference, and 4% indicated that problems had escalated as a result of the program. Sixty-four percent of the families indicated that the whole family was managing better as a result of treatment. The parents indicated that they became angry, lost control, or criticized their children on a less frequent basis and reported the acquisition of more effective discipline skills. Although some were not statistically significant, outcome measures for the children revealed changes in the positive direction. A large improvement in the number of police contacts was not witnessed; however, the number of children involved in this behavior was minimal. Significant changes in the five scales of the Peterson-Quay Behavior Problems Checklist were noted. Ninety-seven percent of the children returned to the families from which they were admitted. A two percent readmission rate was observed over the three year history of the program.

A one-year follow-up report on the effects of long-term hospital treatment of children and adolescents was conducted by Berland and Safier (1988). Subjects were patients at the Children's Hospital of The Menninger Clinic, a long-term treatment facility. Upon admission, each patient received a full diagnostic examination, including a psychiatric examination, family assessment, psychoeducational assessment, psychological evaluation, and recreational, nutritional, speech and hearing, physical, and neurological examinations. Patients were placed on a unit which had an assigned director (child psychologist or psychiatrist), a social worker, and child care workers. There was an accredited school on site and nearly all patients received individual psychotherapy. The treatment philosophy of the program was rooted in dynamic psychiatry based on psychoanalysis, developmental psychology, and family systems.

Patients (N = 42) were grouped into three major diagnostic categories: psychoses, personality disorders, and neuroses. Results, obtained from telephone interviews with youth and parents, revealed that more than two-thirds had a positive outcome at one year follow-up and almost 75% of those with personality disorders had improved. Although follow-up revealed that most of these children did make adequate adjustments following discharge, the results should be viewed with caution due to the small sample size.

Blumberg (1992) conducted a study to assess the general treatment effects of an inpatient/day program unit of a children's psychiatric hospital. The hospital provided a behavioral treatment milieu, including tokens, time out, and locked seclusion. Subjects (N = 115) exhibited severe emotional and/or behavioral problems that required a restrictive environment. Parents and teachers completed a standardized behavior checklist to assess general level of functioning at time of admission, three months after admission, six months following discharge, and one year postdischarge. Results revealed that the children's behavior tended to improve following treatment in the hospital. Poor initial response to treatment as well as a diagnosis of ADHD were predictive of poor outcome.

A more recent follow-up study was conducted to determine short-term outcomes for sixty-five children discharged from a child psychiatric unit (Kalko, 1992). The children received the following primary diagnoses: conduct disorder, ADHD, major depression/dysthymia, oppositional disorder, anxiety disorder, adjustment disorder, and other mental disorders. During hospitalization, children were exposed to several therapeutic interventions, including a behavioral unit-wide point system, group therapy, medication, cognitive-behavioral skills training, consultation services, family counseling, and parent training. Outcomes were evaluated at two, four, and six months after discharge by parent reports obtained during a structured telephone interview. Analyses of variance revealed no significant effects by follow-up interval or length of stay. Based on parent ratings of their child's behavior for the 24 hours prior to the follow-up interview, children were classified as high or low in follow-up improvement. Based on the literature, predictor variables from three domains were selected for examination: background or diagnostic characteristics; family; and treatment. Poor short-term outcome was found to be predicted by the following variables:

diagnosis of ADHD, older age at admission, child depression or sadness, neurological or psychotic symptoms, limited aftercare services, history of physical abuse, and higher intellectual level. High improvement children were reported to have exhibited greater reductions in externalizing and internalizing behaviors. Parents also acknowledged a more positive adjustment at home. Measures of consumer satisfaction indicated that most children showed some significant change and that individual or group treatment was perceived as the most beneficial intervention for children. However, the services received did not differ as a function of the child's perceived improvement.

In a study designed to investigate the outcomes for children with serious emotional disturbances who were placed in residential treatment for educational purposes, Hoagwood and Cunningham (1992) collected data over a three year period (1987-1990) for 114 students. An analysis of outcome ratings indicated that in over 60% of the cases, no or minimal progress had been made or the student had been discharged with a negative outcome (i.e., had run away). In 25% of the cases, students revealed a positive outcome (i.e., returned to school or school-related vocational training). In 11% of the cases, students remained in residential placement but had made substantial progress. Analyses revealed that positive outcomes were significantly related to shorter lengths of stay, with positive outcomes most likely to occur if the youth was discharged prior to 15 months. No significant relationship was observed between age at placement and outcome or cost per month and outcome. The majority of the respondents (over 2 out of 3 subjects) stated that the availability of community-based services such as day treatment, respite care, intensive in-home family support, and crisis intervention, would have prevented residential placement.

Conclusions and Future Research Needs

Based on the present literature review (see Table 1), it appears that the features of residential treatment vary widely. The residential programs described in this review comprised a wide assortment of placement settings, therapeutic modalities, program components, and costs. Thus, it is difficult to determine those features of residential treatment that are most effective in producing successful outcomes. Although the features of residential treatment vary, one traditionally held perception was that this method of service delivery represented the most restrictive and thus, the most *intensive* form of treatment along the continuum of care. However, during the past decade the service delivery field has experienced a shift in this perception of intensity. That is, appropriate levels of intensive service can be rendered in the child's natural environments through the provision of family preservation and individualized, wraparound services. Thus, home and community-based approaches as well as residential services are now considered to be appropriate avenues for the provision of intensive services (Knitzer, 1993).

Studies on the outcomes and efficacy of residential treatment of children vary widely in their focus and methodology. The majority of research studies presented in the current review did not examine residential care in comparison to other service approaches, but rather focused on the factors relating to outcome. Factors found to be predictive of positive outcome included adequate intelligence; nonpsychotic, nonorganic diagnoses; the absence of bizarre and antisocial behaviors; healthy family functioning; adequate length of stay; and adequate aftercare (see Blotcky, Dimperio, & Gossett, 1984). Based on their review of 34 studies, Pfeiffer and Strzelecki (1990) found the following factors to be related to a positive outcome: a standardized treatment regimen, aftercare services, and less severe child and family dysfunction. Length of stay and IQ were found to be moderately predictive of positive outcome. Hoagwood and Cunningham (1992) found that shorter lengths of stay were associated with positive outcomes. Other studies have documented factors found to be predictive of poor outcome. Blumberg (1992) found that a diagnosis of ADHD and poor initial response to treatment were associated with poor outcome. Kalko (1992) also found that a diagnosis of ADHD was predictive of poor outcome as well as older age at admission, child depression or sadness, neurological or psychotic symptoms, limited aftercare services, history of physical abuse, and higher intellectual functioning.

Other studies included in this review compared residential treatment services to no-treatment groups. Generally, these studies found that youth receiving residential services experienced more positive outcomes than youth receiving no services. There are a limited number of studies which examined the effectiveness of residential services as compared to other methods of service delivery.

Currently, no conclusive evidence exists to support the effectiveness of residential treatment over other service types.

Despite the wide variability among residential treatment programs and a lack of rigorously controlled studies, residential treatment services have been found to result in improved functioning for *some* children. Residential treatment plays a significant role in the treatment of children and youth with serious emotional disturbances. However, considerable research is needed before conclusive statements regarding the effectiveness of residential services can be drawn. Future research efforts must concentrate upon determining which youth can most benefit from this type of treatment as well as those treatment approaches which work best with specific populations of children and youth.

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Chapter One

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Table 1
Overview of Studies Examining the Effectiveness of Residential Services

Author or Reviewer	Type of Article	Design	Results/Conclusions
Blotcky, Dimperio, & Gossett (1984)	Summarized 24 outcome studies conducted between 1936 - 1982.	Outcomes of psychiatric hospitalization; single sample design.	Factors predictive of positive outcome: Adequate IQ; nonpsychotic non-organic diagnoses; absence of bizarre & antisocial behaviors; healthy family functioning; adequate length of stay; and adequate aftercare
Dalton, Muller, & Forman (1988)	Reviewed two outcome studies of inpatient treatment.	Single sample design: 1) Outcome of children receiving treatment for conduct disorder and antisocial behavior 2) Skills training vs. no-treatment control	1) Following three months of inpatient treatment, some gains in social relations as measured on a behavioral rating scale, but no significant change in other behaviors. 2) Skills based treatment group receiving treatment in inpatient setting exhibited less aggression and externalizing behaviors than no treatment control group.
Burns & Friedman (1990)	Reviewed results of 4 studies	1) Randomly assigned to treatment & control groups 2) RTC vs. alternative treatment method 3) RTC vs. alternative treatment method 4) RTC	1) No difference between groups at discharge. At follow up, hospitalized youth were twice as likely to be in institution. 2) No significant benefits from residential treatment when compared to alternative. 3) No significant benefits from residential treatment when compared to alternative. 4) Support for the effectiveness of RTC. Post discharge support necessary to maintain treatment gains.
Pfeiffer & Strzelecki (1990)	Reviewed and assessed outcome of 34 studies conducted between 1975 and 1990 which examined inpatient psychiatric and residential treatment of children.	34 follow-up single-sample studies.	Factors found to be predictive of positive outcome: standardized treatment regimen; aftercare services; less severe child and family dysfunction. Factors found to be moderately predictive of positive outcome: IQ and length of stay.
Cornsweet (1990)	Reviewed two controlled studies of inpatient treatment.	Random assignment of groups: 1) Hospital vs. hospital-based evaluation/intensive community-based treatment 2) Problem-solving skills training vs. relationship treatment vs. attention-only control group	1) Both groups improved on behavioral and educational variables; family functioning remained constant. 2) At discharge and follow-up, improved behavioral gains for problem-solving skills training group as compared to groups receiving relationship therapy and attention-only.
Curry (1991)	1) Reviewed hospital-based studies 2) Summarized 3 residential treatment-based studies	1) Single sample designs 2) Single sample & follow up	1) Outcomes vary; many improved, others experienced no improvement, and a small percentage displayed negative outcomes. Support and aftercare services are important. 2a) Improved during treatment and majority were functioning adequately at follow-up. 2b) An association was found between adaptation following discharge and the child's perception of support and continuity. 2c) Most children showed improvement during treatment, treatment gains were not predictive of long-term adjustment.

Table 1, continued

Author or Reviewer	Type of Article	Design	Results/Conclusions
Curry (1991) & Quay (1986)	Reviewed 4 studies.	1) Between program study using treatment-no treatment groups 2) Between-program study using between-treatment groups 3) Within-program study using a between-treatment design 4) Across-program study design	1) Those receiving treatment fared better than the no-treatment group; only 50% received a change in their special education placement category of severely behaviorally impaired. 2) No major difference found between groups receiving transactional analysis and behavior modification treatment approaches. 3) Those in the authority-based treatment group committed fewer offenses than those in the self-governing group. 4) For those youth deemed as in need of residential care, results revealed a lower rate of rearrest for those receiving residential treatment than for those receiving community-based treatment.
Ney, Adam, Hanton, & Brindad (1988)	Examined effectiveness of a child psychiatric unit (*N* = 112).	One year follow-up study.	Majority of parents were more frequently able to talk and listen to child. At one-year follow-up, 85% viewed the program as helpful, 8% reported that treatment made no difference, and 4% reported that problems increased following treatment. 64% indicated greater family functioning. Outcome measures for the children revealed changes in the positive direction. 97% of the children returned to their families. A 2% readmission rate was observed over the three year history of the program.
Berland & Safier (1988)	Examined long-term hospital treatment of children and youth (*N* = 42) at Children's Hospital of The Menninger Clinic.	One year follow-up study.	More than 2/3 of the group had a positive outcome at one year follow-up and almost 75% of those with personality disorders improved.
Blumberg (1992)	Examined effectiveness of an inpatient/day program unit of a children's psychiatric hospital (*N* = 115).	Single sample study.	Results revealed that the children's behavior tended to improve following treatment in the hospital. Poor initial response as well as a diagnosis of ADHD were predictive of poor outcome.
Kalko (1992)	Investigated short-term outcomes for children (*N* = 65) discharged from a child psychiatric unit	Follow-up study. Single sample.	No significant effects by follow-up or length of stay. Poor short-term outcome was predicted by a diagnosis of ADHD; older age at admission; child depression or sadness; neurological or psychotic symptoms; limited aftercare services; history of physical abuse; and higher intellectual functioning. Parents reported a more positive adjustment at home. Services did not differ as a function of the child's perceived improvement.
Hoagwood & Cunningham (1992)	Outcome data for *N* = 114 students placed in residential treatment for educational purposes.	Outcome study. Single sample.	In 25% of the cases, a positive outcome was revealed (returned to school or school-related vocational training). Over 60% experienced no or minimal progress or was discharged with a negative outcome (running away). In 11% of the cases, students remained in residential placement but made progress. Positive outcomes were associated with shorter lengths of stay (less than 15 months).

Outpatient Services: *Psychotherapy*

The most commonly utilized mental health service component for children is outpatient therapy[1]. Although there is no widely accepted definition, psychotherapy has been defined by Kazdin (1991) as "an intervention designed to decrease distress, psychological symptoms, and maladaptive behavior or to improve adaptive and prosocial functioning" (p. 785). Outpatient therapy is the least restrictive component along the continuum of care and is usually the first and most frequent type of treatment provided to children and families in need of service (Tuma, 1989). Psychotherapy varies with regard to theoretical approach ranging from psychodynamic, to behavioral or cognitive-behavioral, to a systems approach. In more recent years, a combination of the various approaches is used frequently. Outpatient therapy also occurs in a variety of settings that may include community mental health centers, outpatient psychiatry departments of hospitals, or private offices and is most often provided by psychiatrists, psychologists, social workers, and counselors.

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[1] *For the purposes of this paper, the terms "outpatient therapy" and "outpatient services" are used to refer only to psychotherapy, not to forms of therapy that involve the dispensation of medication.*

Chapter Two

Typically, the child and/or family will receive therapy in an office on a regular basis (Stroul & Friedman, 1986). Thus, outpatient therapy allows a child to remain in his or her home, school, and community while continuing to receive mental health services (McKelvey, 1988).

Due to the wide variety of settings in which outpatient services are delivered, it is difficult to obtain an accurate estimate of the number of children receiving such services. In an examination of mental health service use by adolescents in the 1970s and 1980s, Burns (1991) reported 1986 cross-sectional data for 10- to 18-year olds. The results revealed that the majority (69%) of adolescents who received treatment were served in outpatient settings. Residential treatment centers, inpatient services, and partial hospitalization services were used by a much smaller percentage of adolescents with 8%, 22%, and 3%, respectively. Burns further examined shifts in the use of services over time. In 1975, a total of 228,584 outpatient admissions (68% of the total admissions to mental health services) were reported as compared to 371,307 (69%) in 1986. Thus, an overall growth rate of 62% in the number of admissions to outpatient services was evident from 1975 to 1986.

Along with a variety of social services, psychotherapy is an intervention that commonly is used in the treatment of children and youth with emotional and behavioral problems (Kazdin, 1993). Although outpatient therapy has an extensive efficacy literature, little attention has been given to the effectiveness of this service in the treatment of children and youth with serious emotional disturbance (Burns & Friedman, 1989, 1990). The purpose of this paper is to provide a brief overview of a number of scholarly reviews of studies examining the effectiveness of child and adolescent psychotherapy. For a more detailed and indepth discussion of the issues related to outpatient care for children, the reader is referred to Weisz and Weiss (1993).

Effectiveness and Outcome Research

Review by Eysenck

The earliest review of the effectiveness of psychotherapy was conducted by Eysenck (1952). Based on this review, Eysenck concluded that the use of psychotherapy in the treatment of adults resulted in no greater improvements than those that occurred in the absence of treatment. Although a limited number of studies involving children were included, this initial review led to further investigations of the effectiveness of psychotherapy for children and adolescents (Kazdin, 1991).

Review by Barrnett, Docherty, and Frommelt

In a review of child psychotherapy research conducted since 1963, Barrnett, Docherty, and Frommelt (1991) presented a summary of four reviews. In the earliest review, Levitt noted that the results did not lend support to the use of psychotherapy in the treatment of children. A later review conducted by Wright and his colleagues found that successful outcome status was apparent between termination and follow-up, and that improvement was positively correlated with the number of therapy sessions attended. In 1980, Tramontana reviewed the adolescent psychotherapy literature for the period of 1967-1977. Thirty-three studies of individual, group, and family therapy were included, although only five of the studies were determined to have employed adequate methodologies. Despite this lack of methodologically sound studies, Tramontana concluded that psychotherapy was effective when compared to no treatment. During the same year, Smith and her colleagues examined control studies using meta-analysis[2]. The analysis revealed that those receiving psychotherapy had significantly better outcomes than those in the control condition.

Review by Weisz and colleagues

Weisz and his colleagues (Weisz, Weiss, & Donenberg, 1992; Weisz, Donenberg, Han, & Kauneckis, in press) reviewed four meta-analyses examining the effectiveness of psychotherapy with children and youth. The first meta-analysis reviewed was conducted by Casey and Berman and included 75 studies published during the period of 1952 and 1983. Studies involved children with a wide range of presenting problems and included a variety of theoretical approaches. Results indicated that children who received psychotherapy showed greater improvement following treatment than 76% of children who received no treatment.

The second meta-analysis was conducted by Weisz, Weiss, Alicke, and Klotz (1987) and involved a total of 105 outcome studies published between the years of 1952 and 1983. Children included in these studies were between the ages of 4 and 18 years and the majority exhibited either an internalizing or externalizing disorder. Both behavioral and nonbehavioral interventions were used, with the majority involving a behavioral approach. Similar to the findings of Casey and Berman, the results revealed that children receiving psychotherapy functioned better following treatment than 79% of those in the control group. It was further concluded that behavioral treatments proved to be more effective than nonbehavioral approaches. It should be noted that this conclusion has been questioned by others in the field who, based on reviews of the nonbehavioral literature, stated that "such comparisons are, at best, premature" due to a lack of methodologically sound research (Shirk & Russell, 1992, p. 707). Similarly, in a review of 43 nonbehavioral (traditional verbal and play therapy) child psychotherapy research studies conducted since 1963, Barrnett, Docherty, and Frommelt (1991) concluded that a large number of methodological flaws were apparent which restricted the accuracy of conclusions regarding the efficacy of these nonbehavioral approaches.

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[2] *Meta-analysis developed by Glass, McGaw, & Smith (1981) is a "set of quantitative procedures that can be used to evaluate multiple studies" (Kazdin, 1991, p. 786). An effect size, the calculated difference between means of a treatment and control group and divided by the standard deviation of the control group, is computed which then provides a summary statistic that allows for the impact of other variables to be examined.*

The third meta-analysis included in the review was conducted by Kazdin, Bass, Ayers, and Rodgers and involved studies published between 1970 and 1988. Studies utilized a variety of intervention approaches and involved children who exhibited internalizing, externalizing, and learning-academic problems. A total of 105 studies comparing treatment and control groups were analyzed. For studies involving treatment versus no treatment groups, children who received treatment exhibited greater improvement than 81% of those in the control group. For those studies comparing treatment and "active" control groups, children who received treatment functioned better than 78% of those in the "active" control group.

Lastly, preliminary data resulting from a meta-analysis conducted by Weisz, Weiss, Morton, Granger, and Han were reviewed. This comprehensive review incorporated 110 studies published between 1967 and 1991 which involved children ages 2 to 18 years. The majority of children exhibited either externalizing or internalizing problems, and the majority of studies involved the use of behavioral interventions. Meta-analytic procedures revealed that following treatment, children receiving psychotherapy functioned better than 76% of those in the control group.

Review of specialty meta-analyses by Weisz et al.

Five specialty meta-analyses were reviewed by Weisz and his colleagues (Weisz, Weiss, & Donenberg, 1992; Weisz, Donenberg, Han, & Kauneckis, in press). These studies included an examination of the effectiveness of family therapy as conducted by Hazelrigg, Cooper, and Borduin; a review of studies investigating the effectiveness of cognitive-behavioral therapy with 4- to 13-year olds conducted by Durlak, Fuhrman, and Lampman; a review of outcome studies which examined the effectiveness of self-statement modification (SSM) with children aged 5 to 16 years conducted by Dush, Hirt, and Schroeder; a review of outcome studies examining the efficacy of cognitive-behavioral methods in the treatment of child impulsivity conducted by Baer and Nietzel; and a recent exploration of the impact of child psychotherapy on the language proficiency of children conducted by Russell, Greenwald, and Shirk. Each of these studies provided evidence to support the efficacy of psychotherapy.

As can be seen, meta-analyses have provided a *general* conclusion supporting the effectiveness of psychotherapy with children and adolescents. However, Weisz, Weiss, and Donenberg (1992) have stated that such a conclusion may be "premature." That is, the treatment conditions under which these studies have been conducted are not representative of standard clinic-based therapy. Thus, it is not known whether the findings derived from the studies conducted under "controlled laboratory settings" can be generalized to therapy conducted in clinics. To that end, Weisz and his colleagues (Weisz & Weiss, 1993; Weisz, Donenberg, Han, & Kauneckis, in press; Weisz, Weiss, & Donenberg, 1992) reviewed the findings of several clinic-based studies which met certain specifications (see Weisz, Donenberg, Han, & Kauneckis, in press, for a description of the criteria used to select studies for inclusion in the review).

Review of clinic-based studies by Weisz et al.

The first study reviewed was conducted by Shepherd, Oppenheim, and Mitchell in 1966 and examined matched pairs of treated children with children in the general population ($N = 50$ pairs). At two years following initial assessment, in-home clinical interviews revealed improvements for 63% of the clinic cases and 61% of the nonclinic cases. There was no relationship between the number of treatment sessions and subsequent improvement.

A study by Witmer and Keller was reviewed which compared the outcomes of children who received treatment (*n* = 85) with those who received only a diagnostic evaluation (*n* = 50). The two groups were followed for a period of 6 to 13 years following contact with a child guidance clinic. Results indicated that 28% of the treated children were rated as *successful* as compared to 48% of those who received only a diagnostic evaluation. A greater percentage (30%) of individuals in the evaluation-only group were rated as *improved*, while 26% of those in the treatment group received such a rating. Overall, those who received only an evaluation had better long-term outcomes than those who received treatment.

Weisz and his colleagues reviewed four clinic-based studies conducted by Lehrman, Sirluck, Black, and Glick in 1949; Levitt, Beiser, and Robertson in 1959; Ashcraft in 1971; and Jacob, Magnussen, & Kemler in 1972. These studies were designed to compare treated and untreated children, both of which had been admitted to the same facility during the same period of time but with those in the control group comprised of children who dropped out before receiving treatment. The earliest study found that at one year follow-up, the percentage of cases classified as being successful were significantly higher for those who received treatment (*n* = 196) than for those in the control group (*n* = 110), while the percentage of cases rated as failures were greater for those in the control group. The second study assessed outcomes on 26 variables approximately five years following clinic contact. No significant differences were noted between the treatment group (*n* = 237) and the control group (*n* = 93). Further, no differences were found between the control group and those in the treatment group who received ten additional therapy sessions. The third study consisted of a five-year follow-up study of children receiving treatment (*n* = 40) and those who dropped out before treatment (*n* = 43). Outcomes were assessed using measures of academic achievement, as these children had been classified as academic underachievers. No differences were noted between the two groups on any outcome measure. The fourth study compared 45 children who received treatment to 42 children who terminated before receiving treatment. Outcome comparisons conducted at one and two-year follow-up periods revealed no significant differences between the groups.

Weisz and Weiss (1989) conducted a recent study investigating the efficacy of clinic-based treatment by examining the outcome of treated youth and those who terminated before treatment. In this study, youth (n = 93) from nine clinics who completed a six month course of therapy were compared with youth (n = 60) who dropped out of treatment following an intake evaluation. Outcomes were assessed at intake, 6 months following intake, and again at one year. Outcome measures included the completion of the Child Behavior Checklist (CBCL) by parents, the parents' identification of the three major problems experienced by their child and the severity of these problems, and the completion of the CBCL Teacher Report Form (TRF) for a subsample of the youth. Results revealed no significant differences in the groups on any measure at six months or at one year following intake.

Two clinic-based studies which utilized random assignment were reviewed by Weisz, Donenberg, Han, and Kauneckis (in press). DeFries, Jenkins, and Williams matched pairs of foster care children who were seriously disturbed on a number of demographic and clinical factors. One member of each pair was randomly assigned to receive standard foster care services while the other group received psychotherapy and enhanced foster care services. Following therapy, children were rated as *improved, no change,* or *worsened.* No significant differences were noted between the two groups. Further, institutionalization occurred more frequently among those in the treated condition as compared to those in the comparison group. A second and more recent study conducted by Smyrnios and Kirkby utilized a random-assignment study. A total of 30 clinic-referred children and their parents were placed in either time-unlimited or time-limited (12 sessions) psychodynamic therapy or a control group that received minimal contact. Following termination and at 4 year follow-up, some outcome measures revealed no significant differences between the treatment and control groups. Some measures indicated more positive outcomes for those in the minimal contact group than for those in the unlimited treatment group.

Chapter Two

Conclusions and Future Research Directions

In general, most laboratory-based studies examining the effectiveness of psychotherapy for children found an overall positive effect of treatment. However, it has been argued that these laboratory-based studies failed to accurately represent how therapy and treatment are carried out in "real world" clinic-based settings (Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz, 1988; Weisz, Donenberg, Han, & Kauneckis, in press). In fact, the clinic-based studies reviewed by Weisz and his colleagues seemed to indicate that the effects of psychotherapy may not be as positive as the findings of the meta-analyses of research-based studies. The authors have provided a number of tentative explanations for the disparity between psychotherapy outcomes in experimental versus clinical settings (see Weisz, Donenberg, Han, & Kauneckis, in press, for a description of these explanations).

Because few of the clinic-based studies were conducted in recent years and because these studies represent a small data base, most of which are dated, definite conclusions about the effectiveness of clinic-based as compared to laboratory-based therapy can not yet be drawn. Thus, future research must concentrate upon expanding the base of research on clinic-based psychotherapy and identifying those conditions under which the positive effects of psychotherapy can best be achieved.

Further, a limited number of studies have been conducted to examine the *specific* treatment approaches that result in beneficial effects for *specific* types of problems. Thus, a second area of needed research is to examine those therapeutic approaches which work most effectively with specific populations of children. A concise summarization of the direction that future research must take has been described by Saxe, Cross, and Silverman (1988) in the following manner: "The important question may not be about the overall effectiveness of child therapy but about the effectiveness of (a) what therapy, (b) under what conditions, (c) for which children, (d) at which developmental level, (e) with which disorder(s), (f) under what environmental conditions, and (g) with which concomitant parental, familial, environmental, or systems interventions" (p. 803).

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Day Treatment Services

According to Stroul and Friedman (1986), day treatment services for children and adolescents are the most intensive form of nonresidential services currently available. "Day treatment" is broadly conceptualized as any program falling in the middle of the continuum of care, that is between inpatient and outpatient treatment (Topp, 1991). The nature of programs defined as day treatment vary widely with regard to setting, population served, intensity, theoretical approach, and treatment components. For example, the settings of day treatment programs vary from hospital-based to school-based and the populations served range from children with severe emotional disorders to children with developmental delays. Theoretical approaches also vary, in that some day treatment programs implement a psychoanalytic approach while others utilize a behavioral approach. Due to this rather broad conceptualization, no universally accepted definition exists.

Stroul and Friedman (1986) defined day treatment as "a service that provides an integrated set of educational, counseling, and family interventions which involve a youngster for at least five hours a day" (p. 44). Through the provision of a broad

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range of services delivered in a coordinated manner, day treatment programs are designed to strengthen individual and family functioning and to prevent more restrictive placement of children (Research and Training Center for Children's Mental Health, 1985-1986). The term partial hospitalization, which refers to those day treatment programs which are hospital-based, has been defined as the "use of a psychiatric hospital setting for less than 24-hour-a-day care" with children returning to their home each night (Tuma, 1989, p. 193). At the other end of the continuum day treatment programs are school-based day programs. Psychoeducational day school programs have been described as "treatment settings for non-mentally retarded children with severe behavior disorders who are unable to function adaptively in the regular school system" (Baenen, Parris Stephens, & Glenwick, 1986, p. 263). Day school programs usually include collaboration between mental health and special education professionals, a multidisciplinary treatment approach, low student-teacher ratios, service provision to families, and the ultimate goal of reintegration into the educational or vocational mainstream.

Although the specific features of day treatment programs vary widely and no universally accepted definition exists, most include the following components (Stroul & Friedman, 1986, p. 44-45):

- Special education, generally in small classes and with a strong emphasis on individualized instruction;
- Counseling, which may include individual and group counseling approaches;
- Family services including family counseling, parent training, brief individual counseling with parents, and assistance with specific tangible needs such as transportation, housing or medical arrangements;
- Vocational training, particularly for adolescents;
- Crisis intervention, not only to assist students through difficult situations but to help them improve their problem solving skills;
- Skill building with an emphasis on interpersonal and problem solving skills and practical skills of everyday life;
- Behavior modification with a focus on promoting success through the use of positive reinforcement procedures; and
- Recreational therapy, art therapy and music therapy, to further aid in the social and emotional development of the youngsters.

Day Treatment Services

Day treatment is unique in that children receive intensive treatment while remaining in their home and community (LeCroy & Ashford, 1992). Day treatment programs serve the dual purpose of acting as an intensive but less restrictive alternative to hospitalization, as well as providing a means of transition for children moving from inpatient to outpatient care (Tuma, 1989). Further, children may receive day treatment services in combination with community-based residential services to increase the impact of both programs (Stroul & Friedman, 1986).

The concept of day treatment is not a new one (Burns & Friedman, 1990). Day treatment for children began in 1943 with the therapeutic nursery school (Grizenko & Papineau, 1992) but has only recently become widespread (Zimet & Farley, 1985). The following sections will provide a review of the recent literature available on the effectiveness of day treatment for children and youth.

Effectiveness and Outcome Research

Two reviews examining the effectiveness of day treatment and day school programs are available (for a description of the research studies contained in these reviews, please see Baenen, Parris Stephens, & Glenwick, 1986; Zimet & Farley, 1985). It should be noted that the rate of reintegration into regular school settings following day treatment has been the most frequently used outcome criterion for evaluating the effectiveness of day treatment programs. Overall, these two reviews revealed that 65-70% of the children in the studies were reintegrated into regular school settings following successful discharge from the day treatment programs. In general, 80% of the children and youth receiving day treatment services improved on clinical measures, while 20% were expelled or sent to a more restrictive setting, such as a residential treatment center (Burns & Friedman, 1990).

In another literature review conducted by Gabel and Finn (1986), the authors stated that conclusive statements regarding the effectiveness of day treatment for children could not be made. However, based on the literature reviewed in this article, it appears that many children benefit from day treatment, although treatment gains often are modest. Academic and behavioral improvements were noted in a number of studies and the importance of family involvement during treatment was found to be a critical factor in success.

A more recent review of studies evaluating day treatment programs for children has been conducted by Sayegh and Grizenko (1991). Most of the early studies reviewed in this article were descriptive and clinical in nature and often used a single outcome criterion; therefore, interpretation of effectiveness is difficult. In their review of studies which used rate of reintegration into regular school settings as the single outcome criterion, Sayegh and Grizenko (1991) concluded that day treatment decreases the need for residential placement and thus, reduces cost. They caution that many of the studies contained in the review consisted of a heterogeneous population and therefore, day treatment may not be effective with all populations.

Recent studies have been more successful in examining the effectiveness of day treatment through the use of multiple outcome criteria. In addition to reintegration into regular school settings, these studies have included improvements in the child's behavior and academic performance as outcome criteria. Based on their review of studies using multiple outcome criteria, Sayegh and Grizenko (1991) concluded that although improvement rates for students receiving day treatment services were generally around 67%, most children continued to require long term special educational services following discharge. The authors further concluded that day treatment "is particularly beneficial for children and adolescents with any of the following problems: conduct disorders, attention deficit disorders, adjustment disorders, developmental delays and withdrawn but with normal nonverbal intelligence and severe emotional disturbances. Children referred to day treatment for severe behavior problems often do not improve and tend to drop out of treatment earlier and more often than other children" (Sayegh & Grizenko, 1991, p. 251).

In the following sections, more recent studies (1987 to present) reviewed by Sayegh and Grizenko (1991) will be summarized briefly, as well as additional studies not included in their review. Sack, Mason, and Collins (1987) conducted a long-term follow-up study of children enrolled in a psychiatric day treatment center which served children with severe emotional disturbances. The program philosophy was basically psychodynamic, psychoeducational and milieu oriented in nature. Each child received a comprehensive assessment and individual treatment plan. Children attended small classes staffed by one milieu therapist and a classroom teacher. Classroom staff were supervised by a multidisciplinary team of professionals. Parents often served as classroom volunteers and received outpatient therapy as well. A total of seventy-nine children were included in this study. A retrospective chart/record review was conducted for each child as well as a semi-structured follow-up interview with a parent, caretaker, or caseworker to obtain information about the child's current adjustment and behavior, family stability, and use of health and mental health services since discharge. Results revealed that children with emotional disorders (anxiety, depression) fared better at follow-up than those children in the broad category of psychotic or behavioral problems. Family stability was also associated with success following discharge. The importance of postdischarge follow-up services and parent involvement during treatment also were noted. The lack of a control group and the use of retrospective chart/record review are limitations inherent in this study.

Cohen et al. have conducted a number of prospective outcome studies evaluating the impact of a therapeutic day treatment program for delayed and disturbed preschoolers (ages 3 to 6 years). These studies have several methodological advantages over other studies, including a prospective design, the use of a control group, the use of standardized measures, and the availability of demographic information (see Sayegh & Grizenko, 1991). In the first study conducted by Cohen, Bradley, and Kolers (1987), a group of 55 children from a therapeutic day care program and 45 children from community day-care centers were included in the sample. Children attended the therapeutic preschool for half days, 5 days/week for a period of 1 to 2 years. Interventions were designed by a clinical team and carried out by classroom teachers in a playroom setting. Treatment goals were based on the individual needs of each child but most often included the establishment of cognitive, language, social, self-help, and language/communication skills; the establishment of limits on disruptive behavior; and assisting the child to become a more active participant, to verbally express feelings, and to observe cause-effect relationships. Families were expected to observe and participate in playroom activities under the guidance of staff and to maintain frequent contact with a social worker regarding marital and family issues. To evaluate the effectiveness of the therapeutic preschool program, a battery of objective developmental, behavioral, and clinical measures was administered at three points during the study: initially, eight to nine months later, and at discharge. Results revealed that children with developmental delays and related emotional and behavioral problems made most gains, especially those with nonverbal intelligence in the normal range. Gains were not observed for those children who presented primarily behavioral and emotional problems, except for some improvements in impulse control. Following discharge, forty-two percent (42%) of the children were integrated into regular school settings, however the treatment group did not perform at the level of the control group on psychometric tests. Findings further suggested that intervention for children with developmental delays must be prolonged (up to two years of continuous treatment) and that the period of time required for observable gains depends on the area of functioning being considered and the child's level of development at preadmission.

Cohen, Kolers, and Bradley (1987) conducted a second study of fifty-three children (ages 3 to 6) at the preschool program described previously. The purpose of this study was to identify variables related to treatment outcome in the therapeutic preschool. A battery of measures similar to that of the previous study was administered one month after admission and at discharge. A multiple regression analysis was conducted to examine the relationship between outcome and a number of variables, including initial level of functioning, biological and psychosocial risk indices, age at admission, length of treatment, and degree of parental involvement during treatment. Results indicated that the outcome is most positive for children who function at a relatively high level of development, whose families are motivated, who are younger at admission, and who receive treatment for longer than one year.

Gabel, Finn, and Ahmad (1988) conducted a retrospective study to examine the outcome of a group (N = 52) of predominately African-American children who were severely disturbed served in a hospital-based day treatment program in an urban area. The program served only minority children with severe disturbances from chaotic home environments. The program was mainly psychodynamic in nature with a focus on individual and group psychotherapy. Mental health services were provided by hospital staff, while educational services were delivered by the local school district. Data were collected retrospectively from the records of a children's day hospital over a five year period. Using living arrangement at discharge (home or residential) as the single outcome criterion, the authors found that upon discharge, 56% of the children were recommended for residential placement, while 44% were recommended for continued placement in the home. Variables found to be significantly related to residential placement following discharge included a history of child abuse, parental substance abuse, suicidal behavior, and assaultive/destructive behavior. Day treatment was found to be effective for certain urban, minority children with behavioral difficulties, but less effective if the variables listed above were present at admission. A small sample size, restricted population, the use of retrospective data collection procedures, and the lack of a control group raise important questions about the generalization of these findings to other day treatment settings.

Kosturn, Brown, and Brown (1990) conducted a prospective investigation of the effectiveness of a day treatment program for children with emotional disturbances. The day treatment program accommodated children from age five to twelve years and served only those who exhibited behavior problems both at home and school. Most of the children were classified as having oppositional or conduct disorders. The four major components of the program included day treatment classroom activities, parent training, family therapy, and consultation with school personnel. The program stressed the collaboration of parents, school staff, and therapists in the provision of short-term intensive treatment as an alternative to a more restrictive placement setting. The sample for this study consisted of all children ($\underline{N} = 75$) admitted to the day treatment program between the years of 1980 and 1985. Complete data were obtained on 23 percent of the original number of participants. Standardized parent ratings of child behavior as well as direct classroom observation were used to measure treatment effectiveness. Measures were taken prior to treatment, immediately following discharge, and at three, six, and twelve months following termination. Results indicated that day treatment was associated with significant positive gains as revealed by three standardized parent measures of child behavior. At discharge, parents reported a significant increase in appropriate behavior and a significant decrease in inappropriate behavior as displayed by their child. Further, parental reports indicated that inappropriate behavior was less severe following treatment. Treatment gains were evident at follow-up as revealed by two parent measures administered beyond termination. No significant change in classroom behavior was observed following treatment. This lack of significant change in classroom behavior has been attributed to the fact that behavior was observed only once before and after treatment and that observation periods were of a brief duration (30 minutes). The small number of subjects and the lack of a control group are additional limitations of this study.

Orchard and MacLeod (1990) conducted a two year retrospective review of a day program that served a population of adolescents from 12 to 19 years of age. Program components included group and individual therapy, recreational activities, and life skills and social skills training. In addition, each youth was assigned to a staff person who functioned as a case manager and an in-program therapist. Results for this study were obtained through a review of the records/charts of 97 youth who attended the program over a two year period. Attendance and adjustment to community living were used to measure the success of the program. Using these measures, the day treatment program was determined to be successful in treating this population of troubled youth. The average rate of attendance was 69%. That is, youth attended the day program approximately three out of four days. Additionally, improvement in adjustment to community living was observed at discharge. Approximately 80% of the youth were attending school or work, thus indicating an improvement in community functioning. Further, at discharge almost 77% were living with family or in other community settings, such as group homes or independent living environments. The authors note that these conclusions should be viewed with caution due to the lack of rigorous methodology.

Two additional studies conducted by Grizenko and colleagues examined the effectiveness of a psychodynamically oriented day treatment program for children with behavior problems (Grizenko, Papineau, & Sayegh, 1993; Grizenko & Sayegh, 1990). Children admitted to this day treatment program receive services for an average of seven months. Treatment goals are individually based but often include assisting the child in understanding the cause-effect relationship of family functioning and the child's behavior; allowing the child to express his or her feelings verbally as opposed to behaviorally; building the child's socialization skills, peer relationships, self-esteem and communication skills; and improving academic performance. Program components included special education services, play therapy, social skills group therapy, psychodrama, and group therapy. On a weekly basis, families received family therapy based on a systemic approach. The dispensation of medication was used when deemed necessary. In the earliest study (Grizenko & Sayegh, 1990), the investigators examined twenty-three consecutive admissions to the program using a single group pretest-posttest design. Children and parents were assessed at admission and discharge using standardized instruments to assess behavioral, academic, demographic, personality, and family variables. Discharge scores revealed a significant improvement on all standardized measures for behavior, academics, personality, and family measures. Although all children showed improvement, parents reported greater improvements in behavior than did teachers or therapists. Significantly lower rates in improvement were observed for children with conduct disorder than for those with attention deficit disorder, oppositional defiant disorder, and depression. At admission only 17% of the children were attending regular school, while at discharge 87% of the children had been reintegrated into regular school settings. Findings must be viewed with caution due to a number of methodological flaws inherent in the study, i.e., a small sample size, the lack of long-term follow-up, and the lack of a control group.

In the second study, Grizenko, Papineau, and Sayegh (1993) attempted to correct the methodological flaws inherent in the previous study by including a control group, a larger sample size, and follow-up at six months. The purpose of this study was to evaluate the effectiveness of a multimodal day treatment program with a psychodynamic orientation for children with disruptive behavior problems (see Grizenko & Sayegh, 1990, for a description of the program). Thirty children, assigned to day treatment or a waiting list (the control group), were assessed using standardized questionnaires measuring behavioral, self-perception, peer relationships, and family and academic variables. Results revealed that the treatment group showed significantly greater improvements on measures of behavior and self-perception. At six-month follow-up, findings indicated that children in the treatment group had improved over time on all measures except academics. The authors concluded that when compared to a control group, those children receiving day treatment services produced greater gains on the measures, and that these treatment gains were maintained at follow-up.

Cost-Effectiveness

As well as representing a less restrictive component in a system of care, day treatment is a less expensive alternative in comparison to residential services. The cost of day treatment for an individual child typically ranges from $10,000 to $15,000 per year, with funding generally provided by multiple sources such as education and mental health (Stroul & Friedman, 1986). Thus, the relative cost savings of day treatment is evident when compared to residential treatment. A number of studies examining the potential cost-savings of day treatment/partial hospitalization were conducted during the 1970s. These studies consistently demonstrated the cost-effectiveness of partial hospitalization when compared to inpatient treatment (see Parker & Knoll, 1990 for a brief review of these studies).

There is a scarcity of studies, however, comparing the cost-effectiveness of day treatment and hospitalization of children and youth. As a result of our literature search, only two studies were found that focused on the cost-effectiveness of day treatment as compared to residential treatment or hospitalization for youth. The earliest study was conducted by Kiser, Ackerman, and Pruitt (1987) and focused on the relative cost difference of treating children in a day treatment program versus inpatient hospitalization for youth. Findings indicated a significant difference in *daily costs*, with day treatment significantly less than inpatient treatment; however, analyses revealed a shorter length of stay for those receiving inpatient treatment than for those in day treatment.

Thus, *total costs* for day treatment and hospitalization were found not to be significantly different. However, due to the nature of the data collection procedures used in the study, it is likely that the reported lengths of stay for the inpatient group were underestimated and thus, unreliable. Therefore, the authors conservatively concluded that "day treatment is at least as cost effective as hospitalization and may be significantly more cost effective" (Kiser, Ackerman, & Pruitt, 1987, p. 25).

A more recent study conducted by Grizenko and Papineau (1992) compared the cost-effectiveness of day treatment and residential treatment for children with severe behavior problems. In this study, data were gathered through a retrospective chart/record review that examined differences in the cost of treating 23 children admitted to a psychiatric facility for residential treatment and 23 children admitted to the same facility after it was converted to a day treatment program. The two groups were similar across a number of demographic, family, social support, and treatment variables. Two relevant findings emerged: (1) the average length of stay for those in the day treatment program was significantly shorter than for those in the residential program and (2) the total cost of treatment for children in the day treatment group was significantly less than for the inpatient residential group. Although a number of methodological limitations are inherent in this study, the authors stated that issues previously neglected in the literature were explored, thus paving the way for future research endeavors in this area.

Summary and Conclusions

Based on the above literature review, it appears evident that the features of day treatment vary widely. The programs described above represent a wide assortment of treatment settings, populations, treatment approaches, theoretical orientations, and program components. Thus, based on the wide variability among program models, it is not possible to draw conclusive statements regarding the program models of day treatment which are the most effective in promoting behavioral and emotional adjustment. Further, there is a lack of clarity regarding who benefits from day treatment.

Despite this lack of ability to draw firm conclusions, three *tentative* conclusions appear to be suggested in the research contained within this review. First, the family plays a significant role in the child's outcomes following day treatment services. A number of studies found that family motivation, family involvement, and family stability during and after treatment were important factors in determining successful outcomes (see Cohen, Kolers, & Bradley, 1987; Gabel & Finn, 1986; Sack, Mason, & Collins, 1987). Secondly, day treatment services may be effective for a limited population of children. That is, most studies found that treatment gains were less likely for children with severe behavior problems than other disability groups (see Cohen, Bradley, & Kolers, 1987; Gabel, Finn, & Ahmad, 1988; Grizenko & Sayegh, 1990; Sack, Mason, & Collins, 1987; Sayegh & Grizenko, 1991). Finally, based on a small number of studies which looked at this variable, evidence seems to suggest that treatment gains have not generalized to the school setting. For instance, Kosturn, Brown, and Brown (1990) found no significant change in classroom behavior following treatment. Also, Grizenko and Sayegh (1990) found that parents reported greater improvements in behavior than did teachers or therapists. Further, the findings of the study conducted by Grizenko, Papineau, and Sayegh (1993) revealed that children receiving services through a multimodal day treatment program had improved on all outcome measures with the exception of academics. Again, these conclusions are tentative and further research is clearly needed.

It should be noted that yet another approach to service delivery which falls under the umbrella of day treatment appears to be emerging. The initiation of interagency systems of care which promote the more effective use of natural settings (i.e., home, school, community) can offer a different perspective of day treatment (Lucille Eber, personal communication, February 14, 1994). At the present time, there are three such programs being sponsored by the U.S. Department of Special Education. One example of such an approach is the WrapAround Project (WRAP) being carried out by the La Grange Area Department of Special Education in Illinois (Eber & Stieper, 1994). Currently, information is available only on the initial phase of the project. The initial phase consisted of a summary of the system's needs assessment which involved the delivery and coordination of wraparound services to 15 youth with emotional and behavioral disabilities and their families. Information gathered from these families led to the proposed systems improvement plan. An 18 month systems planning process was conducted to create an effective system of support and education for youth with emotional and behavioral disorders and their families. The central feature of this project was the development and implementation of a system design based on the wraparound approach. The wraparound approach entails "wrapping" services and supports around children and their families in natural settings. As a result of the planning process, a number of components emerged which included a school inclusion process, an interagency referral and case coordination structure, the development of noncategorical wraparound supports for children and families, a local and state parent advocacy network, and an interagency focus on the reallocation of resources to promote wraparound service delivery. Although the school-based approach described above has only recently begun to emerge, it appears that the concept of day treatment has broadened to include yet another approach to the delivery of services within the rubric of day treatment.

Despite the wide variability in the features of day treatment programs and the difficulty inherent in trying to make conclusive statements regarding their effectiveness, it appears that day treatment is a promising and cost-effective approach in the treatment of some children and youth with emotional problems. Certainly, further research is needed in this area. Sayegh and Grizenko (1991) stated that future research must focus upon determining the types of children and families that benefit most from this treatment approach, areas of functioning that are most affected by day treatment, and those components of day treatment that are most effective. In addition, studies must utilize more stringent experimental designs, implement more sophisticated statistical analyses, incorporate the use of control groups, establish clearly defined outcome criteria, and utilize standardized assessment instruments (Sayegh & Grizenko, 1991; Zimet & Farley, 1985). Further, more data is needed on comparisons of cost and outcomes for residential treatment and day treatment (Steve Forness, personal communication, January 28, 1994).

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Chapter Three

Family Preservation Services

One of the most recently developed approaches in the treatment of children and families is home-based services (Burns & Friedman, 1990), also commonly referred to as family preservation services, in-home services, family-centered services, family-based services, or intensive family services (Anders-Cibik, Zarski, Cleminshaw, & Greenbank, 1990; Cole & Duva, 1990). While a number of both public and private child-serving agencies are involved in the provision of home-based services, most programs share similar characteristics. Based on descriptions set forth in the literature, Stroul and Goldman (1990) have listed the common features of home-based services as follows:

1. The intervention is delivered primarily in the family's home.
2. Home-based services are family-focused, and the family is considered the client.
3. Services have an "ecological" perspective and involve working in collaboration with the community to access and coordinate community supports and services.

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4. Home-based service programs are committed to family preservation and reunification unless there is evidence that the safety of the child is jeopardized.
5. Service delivery hours are flexible in order to meet the needs of the families, and 24-hour crisis intervention services are provided.
6. Home-based services are multifaceted and include counseling, skill training, and assisting the family in obtaining and coordinating needed services, resources, and supports.
7. Services vary along a continuum of intensity and duration based upon the goals of the program and needs of the family.
8. Staff have small caseloads (2 to 3 families) which permit them to work in an active and intense manner with each family.
9. The relationship between the home-based worker and the family is uniquely close, intense, and personal.
10. Home-based programs are committed to empowering families, instilling hope in families, and assisting families in setting and achieving personal goals and priorities.

As noted above, home-based services may vary with regard to service intensity and duration. Family preservation services represent one type of service under the rubric of home-based services. Family preservation services are defined as "short term, in-home, intensive, crisis intervention services" having an ecological perspective and a family-based focus (Yelton, 1991, p. 7). Thus, family preservation services tend to be of short duration (ranging from 1 to 3 months), but are highly intensive (10 to 20 or more hours per week). Services are provided to families in which a child is at imminent risk for placement in a more restrictive setting due to child abuse, neglect, juvenile delinquency, status offenses, emotional problems, or school difficulties (Forsythe, 1992) and usually are rendered only when other interventions have proven unsuccessful (Cole & Duva, 1990). Most family preservation services have three primary goals: (1) to preserve the integrity of the family and to prevent the unnecessary placement of children in substitute care while simultaneously ensuring the safety of the child; (2) to develop an ongoing community support system by linking the family with appropriate community agencies and individuals; and (3) to increase the coping skills of the family and its capacity to function effectively in the community (Stroul

& Goldman, 1990). In addition, family preservation services are used to assist children already in placements to reunify with their families (Anders-Cibik, Zarski, Cleminshaw, & Greenbank, 1990; Stroul & Goldman, 1990). The Child Welfare League of America (1989) has established a set of standards for the delivery of family preservation services. These standards for services provide a thorough description of the goals of family preservation programs which are designed to strengthen and preserve families with children.

There has been a significant increase in the number of family preservation programs over the past decade (National Resource Center on Family-Based Services, 1991). This growth has been attributed to a number of factors:

1. the increasing number of children in out-of-home placements and dissatisfaction with these placements, especially foster care;
2. an increased focus on family integrity and the importance of the parent-child relationship;
3. the move towards an ecological perspective in the provision of treatment rather than a personalistic perspective;
4. the establishment of public policy mandates (e.g., Adoption Assistance and Child Welfare Act of 1980) that strive to preserve families; and
5. the search for less expensive alternatives to care (Whittaker & Tracy, 1990).

Funding/Cost/Cost-Effectiveness

Until the passage of the Omnibus Budget Reconciliation Act of 1993 (H.R. 2264), there was no federal funding stream specifically targeted for family preservation programs (Cole & Duva, 1990). This Act, signed into law in August of 1993, provided new federal funding for family preservation services. Over a 5 year period, one billion dollars in child welfare funds will be provided to states for a variety of early intervention and prevention services with the intent of strengthening, preserving, supporting, and/or reunifying troubled and at-risk children and their families. In the past, most states have re-directed funds to implement pilot projects or family preservation services on a statewide basis. A descriptive study of community-based services for children and adolescents with severe emotional disturbances found that state government represented the major funding source for the provision of home-

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based programs, while the state mental health department represented the second most frequent source of funding (Stroul & Goldman, 1990). The practice of shared financing among various child-serving agencies represents yet another commonly used funding approach. Family preservation services increasingly are being funded through collaborations among departments of mental health, child welfare, and at times, juvenile justice (Knitzer & Yelton, 1990).

The reported costs of providing home-based services vary widely due to differences in intensity and duration of programs, variations in staffing patterns and salaries, and differences in accounting and costing approaches (Hutchinson cited in Stroul & Goldman, 1990). In a comparison of home-based services and out-of-home placements, Polsky (1986) estimated the cost of home-based services as ranging from $3,000 to $5,000 *per episode*, while the cost *per year* of foster care was reported at $5,000, group homes at $10,000, detention at $20,000, residential treatment centers at $30,000, and psychiatric hospitalization at $40,000. Further, costs differentials are substantially greater when one considers that children are often in out-of-home placements for more than one year.

Kinney, Haapala, and Booth (1991) reported the cost-effectiveness of the Homebuilders model of family preservation for sites in Washington State and the Bronx. During 1989 in Washington State, the cost of Homebuilders averaged $2,700 per child for those deemed appropriate for placement. A comparison of the difference between the cost of Homebuilders and various out-of-home placements in Washington State illustrated the cost savings. For example, the total cost of Homebuilders for 60 children was $162,200/year ($2,700/child); however, the cost of foster care for the same number of children was estimated to be $468,780/ year ($7,813/child). When compared to other more restrictive placements, such as residential treatment centers and psychiatric hospitalization, the use of family preservation services resulted in substantially greater cost savings. An analysis of the initial results of the Bronx Project revealed that the cost for Homebuilders services for the first 6 months was $211,892 for all children. This estimated cost is $2,306,048 *less* than the average cost of out-of-home placement for the same number of children.

An examination of the cost-effectiveness of the Families First program in

Michigan as compared to traditional foster care services was conducted over a 6-month evaluation period (Michigan Dept. of Social Services, 1993). Of the 626 families referred to Families First during this 6 month period, 96% of the families were deemed as having children at risk of out-of-home placement by child protective service workers. Assuming that this estimate was correct, the prevention of foster care placement for 96% of the children referred to Families First over the program's 3-year period (*n* = 6,656) could have saved the state more than $55,000,000 for the first year following the family preservation intervention. It should be noted that due to the low cost of the Families First program, cost savings would remain substantial even if a more conservative estimate of the percentage of children at-risk for placement was used.

A financial analysis also was conducted to determine the financial savings achieved through utilization of the Family Ties program operated by the New York City Department of Juvenile Justice (New York City Department of Juvenile Justice, 1993). The average cost for placement in the New York State Division for Youth facility is about $70,000/year/child. This cost is distributed equally between the City of New York and the State of New York. The Family Ties program achieved a total savings of $11,043,318 in placement costs from FY 1989 through the first half of FY 1992. Thus, the savings to New York City was over $5,500,000. The cost-effectiveness of family preservation and family reunification services has been supported in other studies as well (see Berry, 1992; Henggeler, Melton, & Smith, 1992; Woodworth, Hyde, Jordan, & Burchard, 1994). On the basis of these and other studies, it appears that family preservation services are cost-effective in relation to out-of-home placements, especially residential placement settings.

According to Wells (personal communication, February 8, 1994), methodologies used to determine the cost-effectiveness of family preservation services are fraught with difficulties and must be viewed with caution. For example, most cost determinations do not include the cost of follow-up services that accompany family preservation services. To be relevant, all related services used by families during treatment and following service termination must be considered.

Chapter Four

Effectiveness and Outcome Research

Family Preservation Services

The developers of family preservation services have led the way in conducting research to evaluate the effectiveness of this approach. Early evaluations of family preservation services revealed generally positive results; however, these investigations have been criticized for using a single outcome criterion (i.e., the avoidance of out-of-home placement), small sample sizes, and methodological flaws (see Hinckley & Ellis, 1985; Kinney, Madsen, Fleming, & Haapala, 1977). Recent studies have attempted to address these criticisms by examining multiple treatment outcomes, exploring correlates of treatment success and failure, and employing experimental and quasi-experimental research designs (Wells & Biegel, 1991). The most frequently cited literature examining the effectiveness of family preservation services is summarized in the following pages.

Homebuilders

The Homebuilders program, established in 1974 in Tacoma, Washington, is perhaps the best known of the family preservation programs and has served as a model for the establishment of several similar programs across the country. Early reports of the Homebuilders program indicated a success rate of greater than 90%; that is, less than 10% of the children who received family preservation services were placed outside the home (Kinney, Madsen, Fleming, & Haapala, 1977).

Haapala and Kinney (1988) reported the success of a Homebuilders program designed to avert out-of-home placement for status-offending youth who were at risk for foster care or residential placement. Participants in the study were 678 status-offending youth referred to Homebuilders. Youth and their families received family preservation services from one of four Homebuilders programs in Washington State. Placement prevention rates were gathered for youth at 12 months following intake into the Homebuilders program. Of the 678 youth receiving services, 592 (87%) avoided out-of-home placement during the 12-month follow-up period. The remaining youth were placed in foster, group, or residential care. Although the results of this study are promising, findings must be viewed with caution due to the lack of a comparison group and the possible effects of additional counseling services received by the families following termination from the Homebuilders program.

A major study was conducted by Fraser, Pecora, and Haapala (1988) to evaluate the Homebuilders program and to compare it to a similar program in Utah. This study examined the initial outcomes for 453 families and included a 12-month follow-up for 263 families. Overall, greater than 70% of the families remained intact at service termination. At one year follow-up, approximately 66% of the Homebuilders families and over 56% of the Utah families remained intact. Those families that remained together also received improved ratings on a variety of measures, including school adjustment, delinquent behavior, behavior at home, parenting and supervision of children, parental knowledge about child care, and parental attitudes toward placement.

Pecora, Fraser, and Haapala (1991, 1992) examined six intensive family preservation programs and collected pretest-posttest data from families receiving family preservation services in Utah (2 sites) and Washington State (4 sites). For the families in Utah, almost 91% remained intact and for families in Washington State, the rate was almost 94% at case termination. Thus, on the average, 93% of the at-risk children who received intensive family preservation services remained with their families or relatives at termination. A total of 4 children were placed with relatives at or before termination of services. When placement with relatives was considered a service failure, the treatment success rate was 92.3% for children at all sites. For the cases in Utah, the rate was 89.5% and for Washington cases, 93.4%.

Placement prevention rates for the 12-month follow-up group (*n* = 263 families) indicated that treatment gains had declined over time. That is, 67% of the 342 children who were followed for 12 months after receiving family preservation services remained with their families or relatives throughout the year. The placement rates of a small comparison group, (26 Utah families that had been referred for family preservation services, but instead received traditional services) were compared to those in the treatment group. The out-of-home placement rate was higher for those in the comparison group (traditional services) than for those in the treatment group (family preservation services). Out-of-home placement rates for the comparison group were almost twice that of the treatment group when compared at 12 months (85% and 44% respectively).

In addition, a more stringent analysis was conducted to compare the treatment success of the Utah comparison group cases and a matched set of cases who received intensive family preservation services. Cases in the comparison group and the experimental group were matched on the following characteristics: the child's race, gender, school attendance, suspected or substantiated substance abuse, handicap status, and previous inpatient treatment history as well as family income, family structure, and size of household. For the subset of matched treatment cases receiving intensive family preservation services, the placement rate was 44%. This rate was significantly lower than the placement rate for comparison group cases (85%).

In 1987, a Homebuilders program was established in Bronx, New York. The program served children who were abused and neglected. Data collected from May 1987 through August 1988 represented 58 families with 101 children at risk of placement. Approximately 13% of the children were in "official placement" three months after termination of Homebuilders services (Kinney, Haapala, & Booth, 1991); that is, placement settings such as foster care, group care, residential treatment, or hospitalization as opposed to placement with relatives.

Hennepin County, Minnesota

The Center for the Study of Youth Policy at the University of Minnesota conducted an evaluation of a family preservation pilot program established in 1985 (AuClaire & Schwartz, 1986; Schwartz, AuClaire, & Harris, 1991). Families were deemed eligible for participation in the study if they had been approved previously for a home-based placement by both a supervisor and a program manager. A comparison group (n = 58) was comprised of a randomly selected sample of adolescents who were eligible to receive home-based services but could not be served due to the full capacity of the pilot program. The use of all residential placements by subjects was documented over a 12- to 16-month period. Results revealed that youth receiving family preservation services (n = 55) experienced fewer out-of-home placements (56%) then those in the comparison group (91%). *However, the groups did not differ significantly with regard to the incidence of placement when out-of-home placements such as living with extended family or friends was included.* Those in the treatment group experienced fewer days in placement (2,368) in comparison to those in the control group (3,803). The two groups did *not* differ in the average number of placements; however, those receiving home-based services were placed in less restrictive settings.

Maryland

Pearson, Masnyk, and King (1987) conducted a preliminary evaluation of the Intensive Family Services pilot project in Maryland. Evaluation data from 1984 revealed that only 10% of the families receiving services experienced a placement. Further, those counties in which the Intensive Family Services project was implemented experienced a substantially greater decline in the use of foster care than counties in which such services were not available. A more extensive study conducted the following year found that families receiving intensive family services experienced fewer placements and had significantly lower scores on measures of risk to the child as compared to families who received traditional services.

California

In 1984 the California legislature authorized a bill to fund eight intensive home-based service projects with the purpose of preventing foster care placement and lowering the subsequent abuse or neglect of children under the age of fourteen. A 3-year study was conducted by Walter McDonald Associates to evaluate the effectiveness of these programs (see McDonald and Associates, 1990; Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990). During the third year of the projects, an investigation was carried out which examined the functioning of families with one or more children at risk of out-of-home placement. More specifically, the study compared the number of placements for families receiving services from five intensive family preservation service projects across California (the treatment group) to a group of families receiving traditional services (the control group). Families were randomly assigned to either the treatment condition (n = 152) or the control condition (n = 152). Placement data were obtained from time of referral to 8 months following the referral. Results led to the following six conclusions:

1. no significant differences were found in the proportions of treatment and control families that experienced a placement;
2. no significant differences were observed in the number of treatment and control families who were investigated for abuse and/or neglect following their inclusion in the study;

3. no significant differences were observed between the treatment and control groups in the number of days spent in placement;
4. significant differences were found between the treatment and control groups in the number of children placed within two months of referral;
5. children in the treatment and control groups experienced an equal number of placement incidents; and
6. placement days with relatives and foster families "accounted for 91.2 percent of all placement days and 81.9 percent of all placement days and 72.8 percent of [all] of the [placed] children in the . . . experimental group" (McDonald & Associates, 1990, p. 617).

A number of problems, such as high staff turnover rate and difficulty getting referrals from child protective services, were experienced throughout the 3-year project. The evaluation report provides extensive explanations of the difficulties experienced by the project sites (see Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990).

New Jersey

Using an experimental design, Feldman (1991) evaluated the effectiveness of five intensive family preservation programs. Families deemed eligible to receive family preservation services were randomly assigned to either the experimental group (family preservation services, $n = 96$) or the control group (traditional services, $n = 87$) in one of four New Jersey counties. Data were collected on out-of-home placement, family functioning, and family characteristics for up to one year following service termination. Results revealed that early in the treatment program (from 1 to 9 months) significantly fewer children in the treatment group experienced out-of-home placements; however, these differences in placement rates dissipated by the twelfth month of treatment. Further, families in the treatment condition generally failed to improve on measures of family functioning as compared to those in the control condition.

Iowa

Thieman and Dall (1992) reported the results of the evaluation of a statewide family preservation program in Iowa, modeled after Homebuilders. The purposes of the study were to assess changes in family functioning through a pretest-posttest assessment as measured by the Family Risk Scales (see Magura, Moses, & Jones, 1987) and to examine the validity of these scales as a predictor of risk for foster care placement. At the time of publication, data had been collected on approximately 1,500 families. Data collection was limited to families who had been served during 1990-1991, resulting in a total of 995 families. Assessment of the child's risk for out-of-home placement was obtained using the Family Risk Scales. Risk for out-of-home placement was based on three factors: parent-centered risk, child-centered risk, and economic risk. Pretest scores were used to divide the families into categories of higher risk (Group 1) or lower risk (Group 2) for out-of-home placement. Results indicated that the instrument was not useful in predicting out-of-home placement of children at service termination and failed to identify the acute risk characteristics of families referred for family preservation services. Results did indicate modest, but statistically significant, increases in family functioning from initiation to termination of service for both higher and lower risk groups as measured by the scales; however, change was most evident for those in the higher risk group, Group 1. An uncertainty regarding the effectiveness of the instrument in predicting out-of-home placement risk and the lack of a comparison group are limitations inherent within this study. Evaluation activities that address these limitations currently are underway.

Northern California

Berry (1992) conducted an evaluation of the In-Home Family Care Program, an intensive family preservation program in Northern California. Over a 3- year period, data were collected for a total of 367 cases. Measures included case outcomes, client characteristics, and service characteristics. Results revealed that only 4% of the families experienced a placement while receiving family preservation services. Six percent experienced out-of-home placements within 6 months after services were terminated, and 12% of the families experienced a placement at one-year follow-up. Thus, out-of-home placements were avoided in 88% of the families served by this program. The type of service provided was found to have an effect on treatment outcome. That is, concrete services such as teaching family care skills, supplemental parenting, medical care, financial services, and assistance in obtaining food were found to be associated with parents who improved their parenting skills and families that remained together following termination from the program. It appears that this program was effective at preventing foster care placement as well as initiating lasting improvements in family functioning through the provision of concrete services. Further studies are currently underway to examine the re-occurrence of abuse charges upon termination of services.

Texas

Leben and Smith (1992) reported the results of two intensive family intervention projects in Texas. Findings were based on data for 109 youth and families who received intensive family intervention services from August 1989 through April 1991. These two project sites served adolescents with emotional disturbances who either were returning from an out-of-home placement or were at risk for removal from the family setting. Results indicated that the program was successful in avoiding an out-of-home placement during treatment for about 79% of all children. At the end of the project, about 62% of the youth had remained in the home and had not experienced an out-of-home placement. Using a 5-point rating scale, therapists or program directors rated improvement in functioning as compared to initial intake impressions. Almost 25% of the adolescents were rated by their therapists as functioning *much better*, while 33% were rated as *better*. The remaining adolescents were rated as the *same*, *worse*, or *much worse* at the closing of the case. Using the same rating system, therapists rated improvement in parents' functioning following service termination. About 20% of the families were rated as functioning *much better* and about 35% were rated as functioning *better*. Follow-up information indicated that 62% of the adolescents were still living at home. Almost 60% of the families finished the "full term" of treatment and 75% who were referred for additional outpatient counseling went at least once following termination from the program. Thus, it appears that the program was successful in avoiding out-of-home placements for the majority of adolescents in the study; however, placement avoidance rates had decreased by the end of the project. Further, greater than half of the adolescents and families were rated by the therapists as functioning *much better* or *better* at case termination. The findings of this study are limited due to the use of a descriptive and formative design; however, a more comprehensive program evaluation currently is underway.

South Carolina

Henggeler, Melton, and Smith (1992) conducted a study to examine the efficacy of a family preservation program using multisystemic family therapy (MST) in decreasing the rates of institutionalization of youthful offenders and in reducing antisocial behavior. Eighty-four juvenile offenders, judged to be at risk for out-of-home placement, participated in the study. Results revealed that at 59 weeks post-referral, youth who had received family preservation services using multisystemic treatment had approximately half as many arrests as youth who received traditional services. Recidivism rates (rates of re-arrest) were 42% for the treatment group and 62% for the comparison group. Further, results revealed that a composite measure of family cohesion indicated that families participating in the family preservation program experienced greater cohesion, while families receiving traditional services experienced decreased cohesion. A composite measure of aggression toward peers revealed that those youth in the treatment condition had a decreased level of aggression, while those in the control condition experienced no change in aggression as a result of treatment. These findings support the efficacy of a family preservation program using multisystemic therapy in reducing out-of-home placements and in decreasing criminal activity as compared to traditional service delivery methods.

Through a search of archival data, long-term, follow-up data on re-arrest for the above sample (*N* = 84) were gathered for an average of 2.4 years post-referral (Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993). Results revealed that multisystemic family preservation was more effective than traditional services in prolonging the time to re-arrest for this sample. The mean time to re-arrest for those receiving multisystemic family preservation services was about 56 weeks, while the mean time to re-arrest for those receiving traditional services was about 32 weeks. At 2.4 years (120 weeks) post-referral, 39% of those in the multisystemic family preservation group had not been re-arrested, while 20% of those receiving traditional services had not been re-arrested.

Other controlled clinical studies examining the effectiveness of family preservation using multisystemic treatment with adolescents having substance abuse and serious criminal behavior have been conducted (see Henggeler et al., 1994, for a brief review of these studies). Findings from the *Missouri Delinquency Project* represent the most comprehensive and extensive evaluation of family preservation using MST. Chronic juvenile offenders (*N* = 200) were randomly assigned to either a group who received MST or a group who received individual therapy. In addition to recidivism data for 4 years following treatment, pretest-posttest self-report and observational measures were collected to assess individual, peer, and family functioning. Observational measures revealed that families who received MST exhibited more supportiveness and less conflict/hostility in mother-adolescent, father-adolescent, and mother-father relations as compared to those families in the individual therapy condition. Those in the MST condition also reported more family cohesion and adaptability. Adolescents in the MST group displayed significantly fewer behavior problems following treatment and parents reported less symptomatology. Four-year follow-up data indicated that recidivism rates were 22% (MST group) and 71% (individual therapy) for those who completed therapy. Of these recidivists, those in the MST condition were arrested less often and for less serious crimes than those in the comparison group.

Another randomized, controlled study examining the effectiveness of family preservation using MST was conducted in Charleston, South Carolina. Adolescents (N = 112) exhibiting both substance abuse and delinquency problems were randomly assigned to either the MST condition or the usual services condition. A battery of assessment devices were administered at pretreatment, posttreatment, and at 6- and 12-month follow-up periods. Preliminary results from 20 cases revealed that the MST group experienced more gains in abstinence from substance abuse and delinquency resulting in decreased institutionalization as compared to the usual services group (Henggler et al., 1994).

Michigan

In response to increased public concern over a statewide increase in cases of child abuse, neglect, and delinquency, the Michigan Department of Social Services (MDSS) created a family preservation program, Families First, designed to serve as an alternative to traditional child protective service approaches such as foster care. The program provided a range of support services on an intensive, short-term basis to families in crisis.

An evaluation (Michigan Department of Social Services, 1993) was conducted to determine the program's effectiveness in comparison to foster care services in averting children from out-of-home placements. The evaluation involved a group of children (n = 225) who received family preservation services through the Families First Program and a matched group of children (n = 225) who received traditional foster care services.

The study covered a 3-year period and utilized multiple data sources. In an examination of out-of-home placement rates for the two groups, results revealed that children in the Families First program evidenced a consistently lower out-of-home placement rate at 3, 6, and 12 months following the intervention. At 3-month follow-up, out-of-home placement rates were 7% for the Families First group and 15% for the foster care group. Six-month follow-up data revealed out-of-home placement rates of 12% for the Families First group and 26% for the foster care group. Out-of-home placement rates at 12-month follow-up were 24% for children in the Families First group and 35% for those in foster care. Even more striking differences were noted in out-of-home placement rates for the two groups when 39 pairs of children referred due to delinquency and reunification were removed from the analysis. For the matched pairs of children ($N = 186$ pairs) referred due to abuse and/or neglect, respective out-of-home placement rates at 3, 6, and 12 months were 5%, 13%, and 19% for the children in the Families First group and 12%, 26%, and 36% for children who received foster care services.

City of New York

The New York City Department of Juvenile Justice was the first juvenile justice agency in the nation to implement a placement diversion program (Family Ties) based on the Homebuilders model of family preservation (Collier & Hill, 1993). The primary objective of the program was to prevent the unnecessary placement of adjudicated juvenile delinquents by directly intervening in the youth's life and assisting with problem areas that contributed to the delinquency.

A quasi-experimental design was employed to measure outcome differences between youth in the Family Ties program and a group of juveniles not served by the program. Primary outcome measures included rates of re-arrest, re-conviction, and re-incarceration for the year following release from the Family Ties program or, for those in the comparison group, from the state youth facility. Positive behavior changes exhibited by program youths also were used to assess outcome. Former program youth ($n = 93$) were randomly selected for inclusion in the study. Of that number, 57% ($n = 40$ families) consented to an interview. The comparison group was comprised of randomly selected juvenile delinquents ($n = 40$) who were adjudicated in Family Court and placed in a state youth facility. Groups were found to be comparable in background and at-risk variables and had been in the community about the same length of time (1 year) before follow-up.

Results indicated that the program was able to avert from placement an average of 65% of the youth received through court referrals. This placement-aversion rate falls within the normative range for similar family preservation programs. For youth and families participating in the program during 1991-92, six month data indicated that approximately 8 in 10 youth remained uninvolved with the juvenile justice system. No significant difference was noted between 6- and 12-month follow-up. Rates of re-involvement were significantly lower for those in the Family Ties program than for the comparison group. For those in the program, the rate of re-arrest was 20%, while re-conviction and re-incarceration rates were each 18%. For the comparison group, the rate of re-arrest was 42% and the rates of re-conviction and re-incarceration were 40% each. As another measure of outcome, the evaluation focused on the amount of placement time saved as a result of the Family Ties program. On average, in 1992, the program averted almost 6 weeks of placement time during the program and nearly 10 months following participation in the program. For results on the program's model and process, please refer to Collier and Hill (1993).

In a study designed to examine child and family functioning following intensive family preservation services, Wells and Whittington (1993) sought to answer two important questions: (1) how well were families who had received family preservation services functioning at follow-up and (2) did family functioning improve between admission and discharge and, if so, was improvement maintained at follow-up. A sample of 42 families was included in the analyses. A family was eligible to participate in the study if it had a child between the ages of 10 and 18 years who had been referred to the family preservation program. Data were collected from children, parents, and caseworkers at admission, discharge, and one year following service termination.

Sources of data included measures of family and child functioning, the resolution of problems reported at admission, and stability of the child's living situation between discharge and follow-up. Family and child functioning, as measured by three standardized instruments, was defined in terms of the promotion of family health, the elimination or reduction of parent-child conflict, and the amelioration of child behavioral problems. The resolution of admission problems was defined as the degree to which the problems reported by parents and children at admission had improved and the proportion of these problems that had been eliminated by discharge or follow-up as measured by self-report. The stability of a child's living situation between discharge and follow-up was defined as the extent to which the child remained in the home he or she was in at discharge or was scheduled to return to at discharge. The stability measure reflected the number of changes in placement between discharge and follow-up.

Results revealed that, on average, families were functioning at a lower level than the nonclinical samples of families at follow-up. Both children and parents reported the health of their families and their relationship with each other as less adequate and children's behavioral problems as more severe than when compared to nonclinical samples. Children's behaviors and parent-child relationships were evaluated in a more negative manner by parents than by children. Evaluations of family health were similar for both parents and children.

With regard to the resolution of admission problems, parents and children reported that many of the problems apparent at admission were resolved or had improved at follow-up. On average, children stated that more than 50% of the problems they had reported at admission were eliminated or resolved, and for those problems still present, children reported modest improvement since discharge. At follow-up, parents reported, on average, that more than one-third of the problems reported at admission were eliminated or resolved. Parents reported modest improvement for those problems still present.

During the follow-up period, measures of stability indicated that the majority of children (59%) remained in the home in which they had lived at discharge. Of those who did experience placement changes, the highest percentage (47%) moved only once, 41% experienced from two to four placement changes, and the remainder (12%) experienced eight or nine moves. Results of the use of out-of-home placements between discharge and follow-up indicated that 80% of the children used no out-of-home placements, while the remaining children were placed in psychiatric hospitals, group homes, correctional facilities, residential treatment centers, foster homes, or child-care institutions.

In the examination of improvements in child and family functioning over time, results revealed that, on average, the functioning of children and families improved between admission and discharge and did not decline between discharge and follow-up. A statistically significant difference was noted in children's average scores from admission (2.50) to discharge (2.30) to follow-up (2.28) as measured by the Family Assessment Devise-Version 3 (Epstein, Baldwin, & Bishop, 1983). Scores decreased from admission to discharge, but remained essentially the same from discharge to follow-up. Scores on the Child Behavior Checklist (Achenbach & Edelbrock, 1983a) and Youth Self-Report Form (Achenbach & Edelbrock, 1983b) were found to be statistically different over time, with a mean score of 73.15 at admission, 69.73 at discharge, and 62.44 at follow-up. Further, no significant difference was noted between discharge and follow-up in change in admission problems as the level of improvement at discharge was maintained at follow-up.

Family Reunification Services

Utah

Rather than focusing on the use of family preservation as a way of preventing out-of-home placements, Walton, Fraser, Lewis, Pecora, and Walton (1993) examined the effectiveness of family preservation services in reunifying children with their families. This study, conducted in Utah, utilized a posttest-only experimental design. Families were randomly selected from a computer-generated list of children in out-of-home care. The sample was randomly assigned to either the treatment or control group. The treatment condition was comprised of a group of families (*n* = 57) who received family preservation services, while those in the control condition consisted of families (*n* = 53) who received traditional family foster care reunification services. Data were collected at the beginning and end of the 3-month treatment period. Findings revealed that at the end of the 90-day treatment period, 93% of the families in the treatment condition were reunited as compared to only 28% of the families in the control condition. Six-month data revealed that some of the children in the treatment group who had been reunited with their families had returned to an out-of-home placement, while more of the children in the control group had returned to their homes. Of the 53 children in the treatment group who were living at home at the end of the treatment period, 40 (70% of the total treatment group) remained in the home 6 months later. During this time, an additional 7 children in the control group returned home, resulting in a total of 22 (41.5%). Data collected at 12 months after the termination of services revealed that 43 (75.4%) of the children in the treatment group were in their homes as compared to 26 (49%) of the children in the control group. Further, those receiving family preservation services spent significantly more days living at home during the 90-day treatment period and follow-up periods than those receiving traditional services.

New England

Fein and Staff (1993) reported the findings from the first 2 years of a 3-year demonstration project in New England. In 1989, Casey Family Services, a private child welfare agency, expanded its services to include three reunification programs located in Connecticut, Maine, and Vermont. These reunification programs were designed to serve children placed in state family or group foster care due to abuse or neglect and who had a permanency plan which called for reunification with the biological family.

During the first 2 years of the demonstration project, 110 children (47 families) were served by the program. Children ($N = 68$) who had received services for 6 or more months were the focus of the current analyses. During the first 2 years, 26 of the children (38%) had been reunited with their biological families. Of those children, 13 (19%) were at home and still receiving services, 6 (9%) were at home and their case had been closed, and 7 (10%) were returned to out-of-home care. Thus, a total of 19 (28%) children remained reunified with their families by the end of the second year of the project.

Baltimore, Maryland

Woodworth, Hyde, Jordan, and Burchard (1994) presented the findings of two initial studies of the Family Preservation Initiative of Baltimore City, Inc. (FPI) founded in January 1991. Based on a wraparound care model approach for the provision of family reunification services, this initiative was designed to return children from out-of-state placements, divert inappropriate out-of-home and out-of-state placements, and redirect funding streams from out-of-home placements to community-based placements.

Chapter Four

Study 1 examined the effectiveness of FPI services and the use of the principles of wraparound by evaluating the outcomes of youth returned and diverted from out-of-home placements. Participants in the study included all youth returned and diverted from out-of-state care by July 1, 1993. Information was gathered about each youth's history and placement changes. Updated information was collected on a monthly basis. The Restrictiveness of Living Environments Scale (ROLES; Hawkins, Almeida, Fabry, & Reitz, 1992) was used to provide an index of the restrictiveness level of residential placements. Data on adjustment behaviors (school suspensions, psychiatric hospitalizations, attempted suicides, and delinquent arrests) were gathered to monitor the progress of the youth.

Prior to entering FPI service, 20% of the youth were in placements having a restrictiveness level of 5.5 (group home level care) or less. At the end of FY 1993, the percentage of youth having a restrictive level of 5.5 or less had risen to 82%. With regard to the number of residential placements while in FPI care, the majority of youth (65%) had only one placement, 30% had two to four placements, and 5% had five to seven placements. In terms of school placement, 65% had only one placement, 26% had two placements, and 19% had three placements. The following results were obtained for the occurrence of adjustment behaviors: 30% exhibited none of the behaviors, 29% experienced school suspensions, 21% experienced psychiatric hospitalizations, 6% attempted suicide, and 14% experienced delinquent arrests. Parent and youth satisfaction measures of services and programs were obtained by phone. On a scale of 1 (very dissatisfied) to 5 (very satisfied), parents reported an overall mean rating of 3.5 on measures of satisfaction with services, while youth reported an overall mean rating of 3.9. With regard to satisfaction with various program components, parents had an overall mean rating of 3.8 and youth had an overall mean score of 3.5.

Study 2 examined the effectiveness of FPI's services specifically for youth returned from out-of-state placement. Data were gathered for a sample of youth (*N* = 30) who had been returned from out-of-state placement and who had received FPI services for at least 6 months. Results suggested that FPI's methods of returning youth from out-of-state placements assisted them in maintaining less restrictive placements than before out-of-state placement. Those who returned from out-of-state placements revealed a decrease in both level of restrictiveness and number of placements. Further, psychiatric hospitalization was found to be the best predictor of level of restrictiveness following out-of-state placement. That is, youth with a greater number of psychiatric hospitalizations upon return from out-of-state placements were more likely to be placed in more restrictive environments. However, length of out-of-state placement was not found to be related to higher levels of restrictiveness upon return to the state. A second analysis revealed that youth in more restrictive placements prior to leaving the state spent a longer amount of time in out-of-state placements.

Conclusions and Future Research Needs

Based on the studies included in this review, it appears that family preservation services have been effective in averting the placement of a high percentage of children. At service termination, the percentage of children remaining with their families ranged from about 70% to 96% (see Table 1). Most studies, however, did not utilize a control or comparison group. The percentage of children averted from placement tended to decrease at follow-up. However, percentages were greater for those receiving family preservation services at follow-up than for those in comparison or control groups. Few studies have been conducted that examined outcome measures other than placement prevention rates. Of the 18 studies reviewed, only two explored the effects of family preservation services on child or family functioning. Thieman and Dall (1992) found a statistically significant increase in family functioning from admission to termination for those receiving family preservation services. Wells and Whittington (1993) found that family functioning improved between admission and discharge, with no decline apparent between discharge and follow-up. Many of the problems present at admission had been resolved or had improved. Almost 60% of the children had remained in the home in which they lived at discharge.

Similar trends were apparent in the studies which examined the use of family preservation services for the purpose of reunifying families; that is, reuniting children already in out-of-home placements with their families. While the percentage of children reunified was greater for those in the treatment as compared to the control groups, those percentages decreased as the amount of time from discharge increased. In an examination of outcomes other than rate of placement prevention, Woodworth, Hyde, Jordan, and Burchard (1994) found that restrictiveness of placements was less during the period following 6 months of family preservation services than the period prior to out-of-state placement.

While it appears that many family preservation programs have proven effective in keeping families intact and preventing or delaying the placement of children deemed at-risk for substitute care, the effects do not appear to be long lasting, and families continue to be at-risk following service termination. That is, it seems that treatment gains appear to decrease as the amount of time following discharge increases. In an examination of factors related to successful adaptation following the termination of services, Wells and Whittington (1993) found that child and family factors (risk of child removal at admission and formal and informal support of parent following discharge) were more strongly related to family functioning at follow-up than were treatment factors (engagement in treatment and resolution of admission problems at discharge). Further, families with a child at imminent risk of removal at admission were found to be less likely to engage in treatment and less likely to have a high level of family health at follow-up than those with children at lower risk for out-of-home placement.

In a review of the major evaluations of family preservation programs, Rossi (1992) concluded that in spite of the fact that the majority of evaluations involved randomized experiments or close approximations to such designs, definitive findings concerning effectiveness can not yet be ascertained. Small sample sizes and the use of overly simplified analyses strategies commonly were noted as problem areas in evaluations included in the review. Further, the majority of studies currently available have used a single outcome criteria, i.e., rate of placement prevention. A number of evaluators have criticized the use of placement prevention rates as the single criterion to determine the effectiveness of family preservation services (Rossi, 1992). In fact, it has been argued that placement "is an ambiguous indicator of treatment failure. Placement may be a positive outcome for some children. It may be affected by factors unrelated to the functioning of a family or a child, such as the availability of placement resources in a community. Moreover, research has shown that the majority of children admitted to intensive family preservation programs would *not* [italics added] have been placed without the program. Thus, it is difficult to use absence of placement as an indicator of success" (Wells & Whittington, 1993, p. 57). In addition to placement prevention rates, research endeavors must include other criteria, such as the stability of the child's living situation, the quality of the child's living situation (Wells & Whittington, 1993), and changes in the well-being of the child and family (Rossi, 1992).

In addition to the concerns presented above, Usher (1993) asserts that many studies have found little or no difference in the effectiveness of family preservation services in decreasing out-of-home placement rates due to imprecise targeting of admission to family preservation programs and inconsistency in service delivery. He argues that evaluations were conducted despite awareness that these problematic issues were present. For example, evaluations of recently developed programs (Rossi, 1992) or those which are poorly managed are unlikely to reveal positive outcomes.

In light of these and other relevant issues, a number of recommendations for future research can be made. Certainly, definitive conclusions regarding the effectiveness of family preservation services await further research. Wells and Biegel (1991, 1992) have offered recommendations for future research in this area. These recommendations were based on discussions held at the 1989 National Conference on Intensive Family Preservation Services and the available research. Recommendations for future research included the following: (1) investigations to determine what portion of children approved for out-of-home placements meets the criteria to receive intensive home-based services; (2) outcome evaluations to determine the degree to which home-based services are meeting goals, i.e., the prevention of out-of-home placement and the reduction of future crises that may lead to placement; (3) longitudinal evaluations to assess the maintenance of treatment outcomes over time; (4) investigations to evaluate the impact of the ecological features of the program on implementation, functioning, and outcomes; (5) process evaluations to examine the clinical assumptions underlying treatment models and the ways in which clinicians and clients experience programs; (6) comprehensive evaluations of the functioning of children and their families at service termination; (7) investigations of service cost which take into account all services used by families during treatment and following termination; and (8) investigations to explore and examine those factors that act as facilitators and barriers to the replication of services across various settings. More recently, a reorientation for future research in the area of family preservation services has been proposed. Wells (in press) has suggested that research move "toward the development of theoretical knowledge", that is, that the research be placed in a theoretical framework; that research studies investigate critical outcomes, both intermediate and ultimate; and that research from related fields, such as foster care, be used to determine further areas of family preservation services research.

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Table 1
Summary of the Results from Recent Studies Evaluating the Effectiveness of Family Preservation and Family Reunification Services in Preventing Out-of-Home Placement.

	Percent of Children with Family at Service Termination		12 Month Follow-up		Other Frequencies of Follow-up		
Authors	Treatment	Control	Treatment	Control	Treatment	Control	Sample Size
Haapala & Kinney (1988)[a]	–	–	87%	–	–	–	N = 678 status offenders.
Fraser, Pecora, & Haapala (1988)	>70%	–	66%WA 56% UT	–	–	–	N = 453 families at service termination; N = 263 families at 12-month follow-up.
Pecora, Fraser, & Haapala (1991,1992)	93%[b]	–	56%	15%	–	–	N = 581 children initially; N = 263 families at 12-month follow-up and N = 26 families in the control group at 12 - month follow-up.
Kinney, Haapala, & Booth (1991)	87%[c]	–	–	–	–	–	N = 58 families (101 children).
AuClaire & Schwartz (1986); Schwartz, AuClaire, & Harris (1991)	–	–	44%[d]	9%[d]	–	–	n = 55 for treatment group and n = 58 for control group.
Pearson, Masnyk, & King (1987)	90%	–	–	–	–	–	–
McDonald & Associates (1990); Yuan, et al. (1990)	–	–	–	–	No significant differences between treatment and control groups[e]		N = 304; 152 families in the treatment group and 152 families in the control group.
Feldman (1991)	92.7%	85.1%	54.2%	42.5%	–	–	n = 96 families in the treatment group and n = 87 in the control group.
Thieman & Dall (1992)	–	–	–	–	Statistically significant increase in family functioning from admission to termination.	–	N = 995 families
Berry (1992)	96%	–	88%	–	94%[f]	–	N = 367 families
Leben & Smith (1992)	79%	–	62%[g]	–	–	–	N = 109 children
Henggeler, Melton, & Smith (1992) (Rates of Re-arrest)	–	–	–	–	58% (no rearrests)[h]	38% (no rearrests)[h]	N = 84 serious juvenile offenders; n = 43 in the treatment group and n = 41 in the control group.
Henggeler, Melton, Smith, Schoenwald, & Hanley (1993) (Rates of Re-arrest)	–	–	–	–	39% (no rearrests)[i]	20% (no rearrests)[i]	N = 84 serious juvenile offenders; n = 43 in the treatment group and n = 41 in the control group.
Henggeler et al. (1993): Missouri Delinquency Project	–	–	–	–	Families in the treatment group had more supportiveness, less conflict-hostility in family relations, more cohesion and adaptability. Adolescents in the treatment group had fewer behavior problems and parents reported less symptomatology. For those who completed therapy, recidivism rates were 22% for the treatment group and 71% for the comparison group. Tx group were arrested less often and for less serious crimes.		N = 200 chronic juvenile offenders

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Table 1, continued.

Authors	Percent of Children with Family at Service Termination		12 Month Follow-up		Other Frequencies of Follow-up		Sample Size
	Treatment	Control	Treatment	Control	Treatment	Control	
Henggeler et al. (1993): Charleston, South Carolina	–	–	Treatment group had more gains in abstinence from substance abuse and delinquency and decreased institutionalization as compared to the control group.		N=20 cases adolescents with substance abuse and delinquency	–	–
Michigan Department of Social Services (1993)	–	–	24% 19%	35% 36%	7%[k] 12%[f] 5%[k] 13%[f]	15%[k] 26%[f] 12%[k] 26%[f]	N = 450 children; *n* = 225 in the treatment group and *n* = 225 in the comparison group. N = 372 children (186 pairs) from the previous sample who were referred due to abuse and/or neglect only.
Collier & Hill (1993)[l]	–	–	20% rearrested 18% reconvicted 18% reincarcerated	42% rearrested 40% reconvicted 40% reincarcerated	–	–	N = 80 families; *n* = 40 in treatment group and *n* = 40 in comparison group.
Wells & Whittington (1993)	–	–	–	–	Functioning improved between admission and discharge; no decline between discharge and follow-up. Many problems apparent at admission were resolved or improved. 59% had remained in the home in which they lived at discharge.		N = 42 families.
FAMILY REUNIFICATION SERVICES[m]							
Walton, Fraser, Lewis, Pecora, & Walton (1993)	93%	28.3%	75.4%	49%	70%	41.5%	*n* = 57 in the treatment group and *n* = 53 in the control group.
Fein & Staff (1993)	–	–	–	–	38%[n] 28%[o]	–	N = 68 children.
Woodworth, Hyde, Jordan, & Burchard (1994)	–	–	–	–	Restrictiveness of placements was less during the period following family preservation services than the period prior to out-of-home state placement[p]		N = 30 youth.

[a] participants were status-offending youth.
[b] average placement prevention rate was 93%; 92.9% represents only "official placements" (e.g., foster care, group care, residential treatment, or hospitalization); 92.3% represents *all* placements, including placement with relatives
[c] this figure represents only "official placements".
[d] cases were followed from 12- to 16- months depending on when the case was selected. These figures represent only "official placement" rates; no significant difference was revealed when placement with relatives was considered.
[e] follow-up at 8 months
[f] follow-up at 6 months
[g] follow-up data collected at the end of the 2 year project
[h] follow-up at 59 weeks post-referral
[i] follow-up at 120 weeks post-referral
[j] 4-year follow-up
[k] 3-month follow-up
[l] adjudicated juvenile delinquents
[m] rates of reunification for youth already in out-of-home placements
[n] this figure represents family reunification rates *throughout* the first 2 years of the demonstration project.
[o] this figure represents family reunification rates *at the end* of the first 2 years.
[p] after receiving 6 months of family preservation services

Therapeutic Foster Care

According to the Select Committee on Children, Youth, and Families (1989), an estimated 500,000 children were in out-of-home settings with an approximate increase to 840,000 expected by 1995. One of the most widely utilized forms of out-of-home placement for children with serious emotional disturbances is therapeutic foster care (TFC), considered to be the least restrictive form of care among the range of residential services available to children with serious emotional disturbances (Stroul, 1989). In a review of the literature on specialized foster care programs, Webb (1988) found that nearly two-thirds of the programs described their populations as children and adolescents that have emotional or behavioral disturbances.

Therapeutic foster care is a relatively new form of treatment with a variety of models having been developed across the country during the past decade. This service approach has been defined broadly as "a service which provides treatment for troubled children within the private homes of trained families. The approach combines the normalizing influence of family-based care with specialized treatment interventions, thereby creating a therapeutic environment in the context of a nurturant family home" (Stroul, 1989, p. 13). A variety of terms have been used to describe therapeutic foster care, such as specialized foster family care, special foster care, treatment foster care, foster family-based treatment, individualized residential treatment, professional parenting, intensive foster care, and others. For the purposes of this paper, the generic term therapeutic foster care will be used.

Although there is great variability among models and a lack of agreement regarding terminology, most TFC programs share common features. These general characteristics include the following: children are placed with foster parents who have been carefully selected to work with children with special needs; foster parents receive preservice and/or inservice education or training to assist them in working effectively with the child; with occasional exceptions, only one child is placed in a home at one point in time; program staff have small caseloads which allow them to work in a close and intensive manner with each child and family; a support system is developed among foster care parents; foster parents receive a special stipend that is significantly higher than the rate provided to traditional foster parents; and biological families are provided with counseling, support, and other types of assistance (Meadowcroft, 1989; Stroul, 1989). TFC programs differ in such areas as treatment approach, structure, intensity, type of training and support provided, and amount of payment to foster care parents (Research and Training Center for Children's Mental Health, 1986).

A number of advantages of therapeutic foster care programs over other residential services have been noted in the literature. One advantage is the flexibility of the programs. Within this type of program, it is possible to provide services to children of varying ages and with a variety of presenting problems. Further, TFC provides a less restrictive and more natural environment for the provision of treatment; the generalization of treatment gains are enhanced because of the family environment; TFC services are highly individualized; children receive a sense of "connectedness"; and TFC is viewed more positively than other residential treatment programs. With regard to cost, therapeutic foster care programs are relatively easy and inexpensive to start. This is attributed primarily to the fact that no special facility is needed and programs can be started on a small scale with only a few staff and a limited number of treatment homes. Additionally, the cost of therapeutic foster care is lower in comparison to other residential placement settings (Stroul, 1989; Stroul & Friedman, 1986).

Effectiveness and Outcome Research

As a means of evaluating the effectiveness of a TFC program, most studies have examined discharge data. "Successful discharge" is defined as a situation in which the child leaves the TFC program and enters a less restrictive setting, i.e., biological home, adoptive home, foster home, or independent living. Stroul (1989) presented a review of discharge data for a number of therapeutic foster home programs. Overall, the data indicated that successful discharge rates ranged from a low of 62% to a high of 89%. A more recent survey of treatment family-based foster programs in the United States and Canada was conducted by Galaway, Nutter, and Hudson (1992). Survey findings revealed that 66% of the children discharged from these programs were placed in less restrictive settings.

Although many excellent therapeutic foster care programs have been established to meet the needs of children and families, most of the available literature consists primarily of program descriptions, with few attempts to examine effectiveness (Burns & Friedman, 1990; Webb, 1988; Woolf, 1990). Despite the paucity of research, a review of the available literature, published and unpublished, on the effectiveness of TFC is presented in the following sections. For an overview of descriptive studies of the program characteristics of therapeutic foster care, please see Meadowcroft, Thomlison, and Chamberlain (in press).

People Places, which began operating in Virginia in 1973, represents one of the first therapeutic foster care programs to be established for children with serious emotional disturbances (Bryant & Snodgrass, 1992). For 1977, Witters and Snodgrass (cited in Stroul, 1989) reported that of all admissions (N = 26), 89% were discharged to less restrictive settings, while the remaining 11% were placed in institutions. Discharge data from 1981 revealed that of the children admitted (N = 45), 86% were discharged to less restrictive settings (Jones, 1990). People Places also assessed improvements in the functioning of children on various target behaviors from time of admission to discharge. For the two samples mentioned above, greater than 75% of the target behaviors were rated by staff as significantly improved. Target behaviors were rated again at 2 months ($n = 26$) and 7 months ($n = 25$) postdischarge. An average of 80% of the target behaviors were considered to be "no problem" or "some problem, but improving" (Jones, 1990; Snodgrass & Campbell, 1981). Discharge data were collected for the 50 youth discharged from People Places during the 3-year period of 1989-1991 (Bryant & Snodgrass, 1992). The majority (79%) were discharged to a less restrictive setting. Further, 68% had attained their permanency planning goal of adoption or return to family or relatives.

The **Professional Parenting** program was developed in 1979 by the Bringing It All Back Home (BIABH) Study Center in North Carolina. This program represents a less intensive and less structured model of therapeutic foster care, in that, the treatment program is relatively unstructured and relies on the therapeutic value of the home environment and the skills of the treatment foster parents. More structured and intensive treatment services are provided if the initial program appears inadequate. Jones (1990) reported that of the 24 children discharged, 79% of the children were in less restrictive placements upon discharge. The remaining 21% were placed in more restrictive settings, such as psychiatric hospitals, detention centers, or training schools.

Pressley Ridge Youth Development Extension (PRYDE), established in 1981, is a highly structured and intensive foster family-based treatment program for troubled and troubling children and adolescents. The main feature of the PRYDE model is the philosophy of the "professional" parent as the primary "agent of treatment" rather than as a caregiver only. Hawkins, Meadowcroft, Trout, and Luster (1985) provided the results of an evaluation of the PRYDE program. During 1984 (as of September), 13 of the 16 children in the PRYDE program had successful discharges. Thus, 82% of the youth had returned to a less restrictive setting within their community following discharge. Discharge data from 1981-1987 revealed that a total of 72% of the children ($N = 114$) had been placed in less restrictive settings upon discharge. In terms of long-term postdischarge status, 73% remained in less restrictive settings 1-2 years following discharge (Jones, 1990).

Hawkins, Almeida, and Samet (1990) reported the preliminary findings of a comparative evaluation of the PRYDE program and five other out-of-home placement choices. Data were gathered from the files ($N = 461$) of the referring child welfare agency. Twenty-six of the children were served in PRYDE homes, while the remaining were placed in one of the other out-of-home settings. Again, the primary variable of interest was discharge status. On average, children discharged from the PRYDE program were placed in less restrictive settings than those in the other five placement settings. Furthermore, statistically significant differences were found between the level of restrictiveness for those discharged from PRYDE and those discharged from residential treatment centers and intensive treatment units as measured by the level of restrictiveness scale developed by the authors. The average level of restrictiveness of placements following discharge also was calculated between placement settings. Children discharged from the PRYDE program tended to have equally or less restrictive subsequent placements than children discharged from the other five placement settings. However, no data were collected on the level of restrictiveness prior to entering the PRYDE program, thus it is not known if the children were comparable at admission. Follow-up data on all children discharged from a PRYDE program was gathered by phone on an annual basis. One-year follow-up data for 86% of the 110 children discharged between July 1983 and June 1987 revealed that of these children, 76% were living in less restrictive settings one year after their discharge from the treatment home. Seventy-seven percent were either in school or employed (Jones, 1990).

Kaleidoscope, Inc. is a licensed, not-for-profit child welfare agency that strives to serve the most challenging children in the state of Illinois (Kaleidoscope Program Materials, n.d.). One program component within Kaleidoscope is the Therapeutic Foster Family Homes Program. This program provides family living and specialized services on a daily basis to about 65 children and youth who would otherwise be placed in institutions. According to Stroul (1989), discharge data indicated that 62% of the children and youth served by this program were discharged to a less restrictive setting.

Studies were conducted to evaluate the effectiveness of two specialized foster care programs located at the Oregon Social Learning Center (Chamberlain & Reid, 1991; Chamberlain & Weinrott, 1990). Transitions is a specialized foster care program for children and youth with serious emotional disturbances; Monitor is a specialized foster care program for chronically delinquent youth. Evaluations were conducted to determine the effectiveness of these programs.

The evaluation of the **Transitions** program utilized a randomized design in which children from the state hospital were assigned to the specialized foster care program (*n*=10) or to other available treatment settings within their communities (*n*=10). Children receiving specialized foster care services spent an average of 79% of their next year in family-based settings, while those in the comparison group spent only 49% of their time in the community. For the year following placement, the amount of time that children were maintained in community settings was compared for the experimental and control groups. The mean number of days living in community placements was not reliably different for the two groups. However, not all children in the control group (*n* = 7) actually received a placement outside of the hospital setting; therefore, the treatment condition appeared to serve as an effective option for the population of children with serious emotional disturbances participating in this study.

In addition to an examination of discharge status, all participants in the study were assessed across a number of measures. Results of the Child Global Assessment Scale (CGAS: Shaffer et al., 1983), used to measure level of functioning during the past month, indicated that children in both groups experienced major impairment in functioning in several areas. The Parent Daily Report Checklist (PDR; Chamberlain & Reid, 1987), which measured the occurrence of problem behaviors during the previous 24-hour period, was administered at baseline, 3 months, and 7 months. A mean daily rate was calculated for the number of problem behaviors reported for each child at each of the three points in time. At baseline, both groups showed mean daily rates of over 20 reported problems per day. At 3 months, a decrease of over 50% was evident for those in the experimental group, while the control group showed no reduction in mean daily rate of problem behavior. At 7 months, the mean daily rate decreased for the control group, but not to the level of the experimental group. Although a more rapid reduction in daily problem behaviors was evident for the experimental group, no significant group-by-time interaction effect was apparent. The Behavior Symptom Inventory (BSI;

Derogatis & Spencer, 1982), a self-report inventory in which children rate their own level of functioning, was administered prior to placement and at seven months following placement. Members in the experimental group reported twice as many problems as did those in the control group at both measurement points. The Adolescent Problem Inventory (API; Gaffney & McFall, 1981) designed for youth 12 years and older and the Taxonomy of Problematic Social Situations (TOPS; Dodge, McClaskey, & Feldman, 1985) designed for children below the age of 12 were administered to assess the child's level of social competency. No significant improvement was observed for either group on these measures.

A second evaluation study was conducted to determine the effectiveness of the **Monitor Program** which provided specialized foster care services to 12- to 18-year old youths who had a history of chronic delinquency (Chamberlain, 1990; Chamberlain & Weinrott, 1990). Youth (*N* = 32; 16 matched cases) in the Monitor program were matched to other youth with similar characteristics and histories and who had been committed and diverted to traditional community treatment programs, such as group homes, residential treatment centers, or intensive probation. Data were gathered on the number of days incarcerated in state training schools during the one-year follow-up period prior to placement in a diversion program, number of days in treatment, and number of days incarcerated during the 2-year postdischarge period. No significant differences were found for the two groups on number of days incarcerated during the pretreatment period or average amount of days in treatment. However, a greater number of youth in the Monitor group were incarcerated less frequently and for shorter periods of time than those who received an alternative type of service. Further, a greater proportion of youth in the Monitor program (75%) completed their community programs in comparison to those in the control group (31%).

Two year follow-up data on institutionalization rates were gathered for the two groups. Over the follow-up period, a significant difference was found between the two groups. Fifty percent of the youth in the experimental group were reincarcerated at least once during the follow-up period, as compared to 94% of those receiving traditional services. Further, a significant negative correlation was found between the number of days in treatment and the number of days of subsequent incarceration for those in the experimental group. No significant correlation was observed for those in the comparison group.

Clark, et al. (1992) reported the preliminary findings of the **Fostering Individualized Assistance Program (FIAP)** study which compared two methods (Standard Practice or SP and Individualized Support Team or IST) used to identify and meet the mental health and related service needs of foster children with behavioral and emotional disturbances. Children in the SP group received those services which typically were available within the current foster care system, while those in the IST group received individualized wraparound services as provided by a Family Specialist. Family Specialists served a number of case management functions, such as the development of an interdisciplinary team of key figures in the lives of the children; the creation of a plan for the training of key figures; the determination of the service needs of the children and their families, identification of appropriate services to meet these needs, and the delivering and/or monitoring of these services; the preparation of a service plan; the development of a crisis plan and the provision of needed training; and the review and modification of service plans as needed.

Outcome was determined through reliable and valid measures of behavioral and emotional adjustment, academic performance, foster placement status, and birth family interactions. Preliminary data (N = 97 to 102) collected at the 6-month point in the project suggested the following results: (1) based on interviews conducted with caretakers, although the difference is not significant, the number of maladaptive events in the IST group decreased, while the trend for those in the SP group was flat; (2) on the Youth Self Report Scale (YSR; Achenbach, 1991), those in the IST group reported significantly fewer aggressive behaviors and somatic complaints than those in the SP group; (03) a multivariate analysis revealed an overall statistically significant difference on the YSR in the IST group, post-intervention, which was indicative of fewer behavioral problems than the SP group; (4) a general, but not significant, trend toward fewer problems in the IST group as compared to the SP group on all subscales of the Child Behavior Checklist was revealed (CBCL; Achenbach, 1991); (5) on the Social Skills Rating System (SSRS; Gresham & Elliott, 1990), those in the IST group and their caretakers reported higher levels of cooperative behavior following the IST intervention as compared to pre-intervention, while no such trend was observed for those in the SP group; (6) a nearly significant difference in amount of time spent in more restrictive treatment settings was apparent, with IST children spending less time than those in the comparison group; (7) a general but not significant trend toward fewer serious problem behaviors for those in the IST group as compared to those in the SP group was indicated; and (8) a reduction in the annual rate of placement changes for the IST children was observed, while the average placement change rate for the SP group remained fairly constant.

Lee, Clark, and Boyd (1994) reported the preliminary findings of the impact of the IST strategy on delinquency. Analyses involved 132 children (*n* = 54 in the IST group and *n* = 78 in the SP group) of which 16% had some juvenile justice record prior to entering foster care. Juvenile justice records were examined at three points in time: (1) before placement in foster care, (2) after placement in foster care, but before the initiation of the FIAP study, and (3) after the inception of the FIAP study. No significant differences in the percentage of children with delinquency histories or kinds of offenses were revealed between the two groups at the first point in time. At the second point in time, no significant differences were apparent between the IST and SP group. An examination of juvenile justice records at the third point in time revealed that a larger portion of the IST children (35%) experienced no arrests during the post-FIAP period as compared to those in the SP group (29%); however, the difference was not significant. For those children who had no history of delinquent behaviors either before entering foster care or during foster care, results revealed that only a small proportion of youth in both groups (12% for IST group and 18% for the SP group) experienced an arrest. This difference approached significance. For those youth who had delinquency records both before and during the FIAP project, a smaller percentage of those in the IST group (59%) had arrests as compared to 71% in the SP group; again, this difference was not significant.

Case rates, a "statistic in general use for reporting prevalence of delinquency, are defined as the number of arrests officially recorded per 1,000 youths, ages 10 through 17" (Department of Justice, National Center for Juvenile Justice cited in Lee, Clark, & Boyd, 1994, p. 308-309), were calculated as an outcome measure. Results revealed a decrease of 43% in the case rate for IST youth in comparison to the case rate for the SP group which remained essentially the same. IST youth were only 60% as likely to be arrested during the post-FIAP period as compared to youth in the SP group.

The Mentor Program was a short-term, family-based residential treatment model developed to serve as an alternative to psychiatric hospitalization for children (Mikkelsen, Bereika, & McKenzie, 1993). The program utilized a multidisciplinary team of professionals and mentors (specially trained individuals) who worked with the child and the biological family within the home of the mentor. The program shares a number of similarities with treatment foster care; however, differences are evident. The principal difference between treatment foster care and the Mentor Program is the function of the program as the Mentor Program is designed to provide acute care on a shorter-term basis.

Outcome data for 112 consecutive admissions revealed that at discharge, 72% of the children with planned discharges were returned to their family or relatives, 17% were placed in long-term specialized foster care settings, 5% were placed in group homes, and 6% were placed in psychiatric hospitals or residential treatment centers. Three month follow-up data (N = 61 discharged children) indicated that 67.2% were living at home or with relatives, 11.5% were in foster care placements, 4.9% were in specialized foster care settings, 11.4% were in residential placements such as hospitals, RTCs, or substance abuse treatment facilities, and 5% were categorized as "other" or "unspecified".

The **Maryland Department of Human Resources** (1987) examined the effectiveness of specialized foster care services by evaluating improvement in functioning at time of placement and six months after discharge. Measures of functioning revealed that almost all categories of behavior problems decreased for children receiving therapeutic foster care services, while behavior problems increased for those in the control group.

In a report of therapeutic foster care programs in the **San Francisco Bay area**, Beggs (1987) presented the following discharge data for three programs. "Future Families" in Aptos, California, reported that 78% of the youth were discharged to less restrictive settings, while 18% were placed in residential treatment settings. The San Francisco "Therapeutic Family Homes Program" reported that 80% were discharged to less restrictive settings, while 17% were placed in residential treatment centers. The "St. Vincent's School for Boys" in San Rafael, California, reported that only 13% were discharged to more restrictive settings such as residential treatment or group homes.

Bryant, Simmens, and McKee (1989) reported discharge data for the **Missouri Division of Family Services Foster Family Treatment Program**. Data indicated that 74% were placed in less restrictive settings upon discharge from the program.

Two studies examining **specialist foster family care practices in England** have provided support for their effectiveness. Practices are based on the Swedish model of community care for adolescents which incorporates the principles of normalization, localization, voluntariness, and participation. An examination of the Kent Family Placement Project (Hazel, 1989) revealed that the program was effective in serving as an alternative to residential or custodial care for delinquent and severely troubled adolescents. In a comparison of specialist foster family care practices and residential child care practices, Colton (1990) found that overall, the special foster family care programs were found to be significantly more child-oriented than the residential placement settings on four dimensions of care: the management of daily events; children's involvement in community activities; the provision of physical amenities; and the controls and sanctions used by caregivers.

Cost-Effectiveness Research

Therapeutic foster care programs typically are the least expensive service in the range of residential services available to children with serious emotional disturbances (Stroul & Friedman, 1986). Due to the wide disparity among payments made to treatment parents and differences in methods of cost calculation, the reported costs of TFC vary significantly. An overview of the costs of various therapeutic foster care programs, which range from $35/day to $150/day, has been provided (see Stroul, 1989).

Despite this wide variation in cost, TFC compares favorably with the cost of other residential services. A survey conducted by Snodgrass and Bryant (1989) revealed that over 90% of the TFC programs reported their costs to be lower than group homes or institutional placement settings. Other studies and reviews have documented similar cost savings. Bryant (1981) provided evidence of the cost-effectiveness of early therapeutic foster care programs. For example, the Alberta Parent Counselors Program provided therapeutic foster care services to children with emotional disturbances at half the cost of residential care, while the Massachusetts Treatment Alternative Project served children who were scheduled to enter a residential placement setting at two-thirds the cost. People Places provided treatment to children with severe disturbances at half the cost of institutional placement.

A recent comparison of the costs of TFC and other residential treatment settings in California was conducted by Beggs (1987). Again, TFC was estimated to cost less than group homes, sub-acute facilities, and acute hospitals. Hawkins, Almeida, and Samet (1990) conducted a comparison study of a foster-family-based treatment program (PRYDE) and five other out-of-home placement choices (residential treatment centers, specialized foster care settings, group homes, intensive treatment units, and parents). Results revealed that placement in the PRYDE program was less expensive, on a daily basis, than the other placement choices included in the study, with the exception of specialized foster care.

Chamberlain and Reid (1991) examined the cost of a specialized foster care program for youth who had been previously hospitalized. At the time of the study, the hospital program cost was $6,000 per month, while the cost for the experimental program (specialized foster care) was $3,000 per month. Placement in the specialized foster care program saved an average of $10,280 per case in hospitalization costs.

The Kaleidoscope Program also reported substantial cost savings with regard to their Therapeutic Foster Family Program (Kaleidoscope, Inc., n.d.). Cost of treatment in a state institution was estimated to be about $40,000 per child per year, while the cost of the Individualized Treatment Program of Kaleidoscope was $72 per child per day.

The cost of the Mentor Program (Mikkelsen, Bereika, & McKenzie, 1993) was considerably less in comparison to inpatient hospitalization. The average cost per admission to the Mentor Program was reported as $3,825, while the cost per admission for psychiatric hospitalization was $18,030.

Conclusions and Future Research Needs

Therapeutic foster care is a relatively recent form of care for children and youth with serious emotional problems which has become one of the most widely used forms of treatment for this population. There is wide variability among the models of TFC that have been developed and implemented across the nation. TFC programs may differ along the dimensions of treatment approach; structure and intensity; and type of training, support, and stipend provided to treatment foster care parents, but do share some commonalities. As a result of this wide variability, conclusions and generalizations regarding the effectiveness of therapeutic foster care are difficult to reach.

In an examination of the available research on children's mental health services, Burns and Friedman (1990) reported the results of only two studies of TFC effectiveness. Thus, it is evident that a number of additional studies have been conducted since that review. The studies and evaluations of TFC programs included in the current review revealed successful discharge rates ranging from 62% to 89%; that is, between 62% and 89% of the children who received therapeutic foster care services were placed in less restrictive settings upon discharge (see Table 1). This is similar to the range reported by Stroul (1989) in her review of therapeutic foster care programs. A 1992 survey of treatment family-based foster programs in the United States and Canada revealed that 66% of the children are discharged to less restrictive settings (Galaway, Nutter, & Hudson, 1992).

Although the majority of studies have examined discharge rates as the sole outcome criterion, a few studies have investigated the effects of therapeutic foster care services on the child's functioning (Chamberlain & Reid, 1991; Chamberlain & Weinrott, 1990; Jones, 1990; Maryland Department of Human Resources, 1987), time spent in family-based settings (Chamberlain & Reid, 1991; Chamberlain & Weinrott, 1990), rates of incarceration and arrests (Chamberlain, 1990; Chamberlain & Weinrott, 1990; Lee, Clark, & Boyd, 1994), behavioral and emotional adjustment, academic performance, and birth family interactions (Clark, et al., 1992). In general, these studies have reported favorable outcomes for TFC on these dimensions. The data seem to suggest that TFC services do have the potential to effectively serve a portion of children who would otherwise be treated in more restrictive placement settings and can have a positive impact on functioning, adjustment, delinquency, time spent in family-based settings, and other outcomes. Further, cost savings associated with TFC in comparison to other residential treatment settings have been documented.

Several directions for future research have been noted in the literature (see Friedman, 1989; Meadowcroft, Thomlison, & Chamberlain, in press). First, most evaluations have pointed to the general effectiveness of TFC; however, more specific issues must be addressed, such as determining for which populations of children and youth therapeutic foster care works best. Secondly, research must continue to compare TFC with other institutional treatment alternatives as well as with nonresidential placement options. Thirdly, in addition to child functioning, research must investigate the impact of TFC on socially significant areas of children's lives, such as protection from harm, school attendance, or employment. Fourthly, evaluations must focus on determining the critical variables (child, family, and service) that are necessary to produce successful outcomes and to develop empirically-based guidelines. Lastly, efforts must be undertaken to examine the long-term effects of TFC for children and their families.

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Table 1
Summary of Results from Recent Studies of the Effectiveness of Therapeutic Foster Care Programs[a]: Discharge Status Rates[b] and Other Outcomes.

Authors	Percent of children discharged to less restrictive setting		Follow-up Data		Sample Size
	Treatment	Control	Treatment	Control	
PRYDE: Hawkins, Meadowcroft, Trout, & Luster (1985)	82%	–	–	–	$N = 16$
PRYDE: Jones (1990)[c]	72%	–	–	–	$N = 114$
PRYDE: Jones (1990)	–	–	73%[d]	–	–
PRYDE: Hawkins, Almeida, & Samet (1990)	On average, children from PRYDE experienced less restrictive placements than those from 5 other settings.	–	–	–	$N = 461$
PRYDE: Jones (1990)	–	–	76%[e]	–	$N = 95$
People Places: Stroul (1989); Jones (1990)	1977: 89% 1981: 86% For both samples, >75% of target behaviors improved.	–	At follow-up, 80% of target problem behaviors were improving or were no longer a problem.[f]	–	$N = 26$ (1977) $N = 45$ (1981)
People Places: Bryant & Snodgrass (1992)	79%	–	–	–	$N = 50$
Professional Parenting: Jones (1990)	79.2%	–	–	–	$N = 24$
Kaleidoscope: Stroul (1989)	62%	–	–	–	$N = 65$
Oregon Social Learning Center (**Transitions Program**): Chamberlain & Reid (1991); Chamberlain & Weinrott (1990)[i]	Children spent an average of 79% of their next year in family-based settings.	Children spent an average of 49% in the community; only 40% were in family-based placements.	Decrease in problem behavior.[g] No improvement in level of social competency.	Decrease in problem behavior, but did not reach level of treatment group.[h] No improvement in level of social competency.	$N = 20$ ($n = 10$ in treatment group and $n = 10$ in control group)
Oregon Social Learning Center (**Monitor Program**): Chamberlain (1990); Chamberlain & Weinrott (1990)	Youth in the treatment group were incarcerated less frequently and for shorter periods of time. 75% completed community program.	31% completed program.	50% incarcerated at least once[j]	94% incarcerated at least once[j]	$N = 32$ (16 matched cases)

Table 1, continued

Authors	Percent of children discharged to less restrictive setting		Follow-up Data		Sample Size
	Treatment	Control	Treatment	Control	
Fostering Individualized Assistance Program : Clark, et al. (1992)	Children spent less time in restrictive settings than control group.[k]	–	In contrast to the comparison group, the treatment group displayed a decrease in number of maladaptive events; fewer aggressive behaviors; higher levels of cooperative behavior; greater amount of time spent in less restrictive settings; and reduction in annual rate of placement changes.		*N* = 97 to 102[l]
Fostering Individualized Assistance Program : Lee, Clark, & Boyd (1994)[m]	–	–	A decrease of 43% in the case rate[n] for those in the treatment group.	No change for those in the comparison group.	*n* = 54 in the treatment group; *n* = 78 in the comparison group.
The Mentor Program: Mikkelsen, Bereika, & McKenzie (1993)	72% to family or relatives; 17% to TFC settings.	–	67.2% to family or relatives; 4.9% in TFC settings; 11.4% in foster care.	–	*N* = 112 (at discharge) *N* = 61 (at follow up)
Maryland Department of Human Resources (1987)	–	–	Almost all areas of problem behaviors decreased.	Behavior problems increased.	–
Future Families: Beggs (1987)	78%	–	–	–	–
San Francisco Therapeutic Family Homes Program: Beggs (1987)	80%	–	–	–	–
St. Vincent's School for Boys: Beggs (1987)	87%	–	–	–	–
Missouri Division of Family Services Foster Family Treatment Program: Bryant, Simmens, & McKee (1989)	74%	–	–	–	–

[a] The generic term Therapeutic Foster Care (TFC) is used to refer to a service approach that provides treatment to children within the private homes of trained families. Other commonly used terms include specialized foster family care, treatment foster care, intensive foster care, professional parenting, and others.

[b] Discharge status rates refer to the percentage of children that receive a "successful discharge", defined as a situation in which the child leaves the TFC program and is able to go to a less restrictive setting.

[c] Discharge data from 1981–1987.

[d] One to two years following discharge.

[e] One year data for those discharged between 1983–1987.

[f] At 2 months and 7 months postdischarge.

[g] At 3 month follow up.

[h] At 7 month follow up.

[i] Data for December 1989–December 1991.

[j] Two year follow-up data.

[k] A nearly significant difference was found in amount of time spent in more restrictive settings.

[l] Data collected at 6-month point in project.

[m] Examined impact of intervention on delinquency rates only.

[n] See page 13 of text for a definition of case rate.

Chapter Five

Crisis Services

Within the system of care model proposed by Stroul and Friedman (1986), crisis and emergency services were defined as "an important set of services that serve both youngsters who are basically well-functioning but experience periodic crises, and youngsters with longer-term, more serious problems who are prone to acute episodes at which time they require special services" (p. 46). The underlying goals of crisis services are to assist the child and family in resolving the crisis situation and to deter hospitalization.

Crisis and emergency services range from nonresidential to residential settings and involve various types of agencies, services, and personnel (Stroul & Goldman, 1990). Nonresidential services include crisis prevention, identification, and management services; crisis telephone lines; emergency outpatient services; mobile crisis outreach services, including emergency medical teams; and intensive home-based interventions. In some cases, however, the needs of a child or family in crisis can *not* be met adequately through nonresidential crisis services and require residential crisis services. Examples of residential crisis services include runaway shelters, crisis group homes, therapeutic foster care programs used for short-term crisis placements, hospital emergency rooms, and crisis stabilization units. When other approaches to crisis intervention are not appropriate, inpatient hospitalization serves as another source of placement.

Despite the variability among this range of crisis services, community-based crisis services share a number of common characteristics. These characteristics, as outlined by Goldman (1988), are as follows:

1. crisis services are available 24 hours a day, 7 days a week;
2. community-based crisis programs share the common purpose of the prevention of hospitalization and the stabilization of the crisis situation in the most normalized setting available;
3. crisis services are offered on a short-term basis;
4. the capacity of crisis programs tends to be limited to small numbers of youth;
5. typically, crisis services include evaluation and assessment, crisis intervention and stabilization, and follow-up planning;
6. to the extent possible, families are involved in all phases of crisis treatment;
7. staff in crisis programs tend to share similar characteristics, such as flexibility and adaptability, a high level of skill and competence, a high level of energy and dedication, an ability to establish a relationship quickly and to terminate, and the ability to work as a part of a team; and
8. crisis programs usually are part of a larger agency that offers other services, such as inpatient, day treatment, or outpatient services.

Funding/Cost

Information regarding the costs and financing of crisis programs for children is scarce. In a study of community-based services for children and adolescents with severe emotional disturbances, Stroul and Goldman (1990) gathered financial data on crisis services from a small number of programs. Findings revealed that most of these crisis programs were funded through a combination of sources that included contracts or funding support from state or local public sector human service agencies, federal grants, private sector funds, philanthropic donations, third-party reimbursements, and patient fees. Data on costs also were limited. Although costs were calculated in a variety of ways which made comparisons difficult, it was concluded that the costs of crisis programs "are dramatically less than the average cost of private psychiatric hospitals" (p. 73).

Effectiveness and Outcome Research

Adolescent Crisis Team and Respite House

Goldman (1988) provided an extensive overview of the Adolescent Crisis Team and Respite House which operated from the South Shore Mental Health Center in Quincy, Massachusetts. The overarching goal of both programs was the provision of services to youth and their families who were experiencing severe behavioral, psychiatric, or emotional distress. The Adolescent Crisis Team was a multidisciplinary team of professionals which provided 24-hour emergency service to adolescents and their families who were experiencing a crisis. The Respite House, a home located in a residential neighborhood, served as an alternative to psychiatric hospitalization for youth who were experiencing psychiatric crisis and were at-risk of hospitalization. Services provided by the Adolescent Crisis Team included assessment, short-term crisis intervention and stabilization, intensive family-oriented treatment, case management, group treatment, referral, and case coordination. The Respite House served as a residential home for up to two youth and acted as a diagnostic center, holding environment, and treatment milieu.

The South Shore Mental Health Center implemented no formal evaluation process based on outcome measures. However, agency data revealed an 89% reduction in adolescent admissions to the state hospital psychiatric unit during the 2-year period following the development of the Adolescent Crisis Team. Statistics for 1984-1988 revealed that hospital admissions remained relatively stable, while admissions to the Respite House increased.

Children's Crisis Intervention Service

An extensive overview of the Children's Crisis Intervention Service (CCIS) was presented by Goldman (1988). CCIS, a community-based residential program, provided crisis intervention and stabilization services to youth in southern New Jersey. This crisis service was a component within the system of care for youth developed by the Transitional Residence Independence Service (TRIS), a psychiatric rehabilitation agency serving children, youth, and adults in the state. Services provided by CCIS included psychiatric evaluation; individual, group, and family counseling; education, recreation, and skill building activities;

case management and advocacy services; and referral services.

As is true for a majority of crisis programs, no formal evaluation component existed. However, descriptive statistics were provided on the number of youth who were stabilized in the least restrictive setting and returned to community-based placements following discharge. In 1987, 61% of youth who received services returned to their homes. Twelve percent (12%) of the cases were placed in foster homes in which the majority received intensive specialized counseling through TRIS. Twenty percent (20%) were placed in other residential settings, such as group homes or residential treatment centers. The remaining 7% were hospitalized. A 10% recidivism rate for youth returning for at least one other placement was reported. More formal evaluation procedures are planned.

In 1988, the Children's Mobile Outreach Program (CMO), a program designed to provide immediate crisis intervention in the client's home or community, was created as an additional service component within TRIS. A team of mental health professionals arrived at the site of the crisis, and psychiatric and psychosocial interventions were employed. Once stabilization was reached, a short-term plan of action was designed. Additional in-home counseling sometimes followed the initial crisis response, and clients were linked to other community service providers.

Moore (1991) presented preliminary data from a retrospective analysis of 243 client charts for the period of July 1, 1988 to December 31, 1989. Findings revealed that, for an 18-month period, 76% of the clients who received maximum outreach services from the Children's Mobile Outreach were diverted from placement in a hospital setting. For those who received assessment and minimal crisis intervention, almost 39% of the clients referred were diverted from hospitalization. Further, costs associated with the mobile outreach program compared favorably to institutional programs.

Huckleberry House

Huckleberry House, a private, nonprofit organization, was founded in 1970 to provide emergency shelter, crisis counseling, and long-term counseling to children and families (Goldman, 1988). The primary mission of Huckleberry House focused on assisting runaway youth to regain control over their lives, to facilitate the building of communication and understanding between youth and adults, and to prevent subsequent runaways and further deterioration of the family relationship. Huckleberry House provided an array of services, including shelter and crisis counseling programs, a voluntary long-term counseling program for adolescents and their families which included aftercare services, and follow-up services. Information and referral services, educational programs for community groups, and training for volunteers, peer counselors, and students in the human services professional programs also were provided.

Information on the clients served as well as documentation of staff and agency activities was gathered. Outcome data on the approximately 700 youth served each year indicated that 53% of these youth returned to the primary family home while 18% were placed in another home setting. Seven percent were placed in institutional settings and 6% were placed through the children's service agency. A legal alternative was achieved in 85% of the cases. Seven percent of the youth were not admitted to the program, and another 7% returned to the streets. In over 75% of the cases, youth engaged in efforts with a parent or parents to improve communication and seek solutions to their problems. Of the 47% referred, over half of the families participated in aftercare services. Forty-six percent (46%) had no contact with the juvenile justice system, while 19% had brief contact only. Information on 77% of the youth was gathered through follow-up phone calls. This information revealed that 83% had no subsequent episodes of running away from home. About 5% returned to Huckleberry House on multiple occasions.

Systemic Crisis Intervention Program

The Systemic Crisis Intervention Program (SCIP) at the Houston Child Guidance Center, an outpatient treatment program for suicidal children and adolescents, strives to restructure the client's family and social network. The occurrence of the crisis situation is used as an opportunity to assist the family in learning about the "inherent crisis-intervening potential of their natural networks" (Gutstein, Rudd, Graham, & Rayha, 1988).

Initial contact with the family in crisis typically was conducted by telephone. Following telephone contact, a 3-hour evaluation was conducted and short- and long-term goals were determined. Then, families (including extended families) were prepared for crisis gatherings consisting of two 4-hour meetings in which crisis team members and family members attempted to develop a process of reconciliation among family members to prevent future crisis-provoking situations. Following crisis intervention, families were referred for additional outpatient therapy.

Gutstein and Rudd (1990) conducted a study to examine the safety and effectiveness of SCIP. Participants were 47 children and adolescents accepted for treatment by SCIP. Subjective parent ratings and objective measures of patient behavior were used to assess the clinical effectiveness of the program. Using Likert-type scales, parents rated the severity of the child's problem as well as family and marital functioning. A problem checklist was administered to monitor the number of problem episodes experienced by the child. An adaptive behavior scale was used to assess the adaptive functioning of the child in school, family, social, and interpersonal areas. Measures were administered during initial intake and at follow-up (3, 6, and 12 to 18 months). Additional information was gathered regarding the number of problem episodes since last contact, status of ongoing treatment, and suicidal or other crisis behaviors exhibited by the child.

Results revealed that of the 47 children participating in the study, two engaged in suicidal behavior within 6 months of treatment; however, physical harm was minimal. No suicide attempts were made during treatment. There were no reports of injury to either the clients or family members during treatment or the follow-up period. At the outset of treatment, the majority of parents rated their child's presenting problems as "severe" or "catastrophic," while only a small number reported these same ratings following treatment. Adaptive behavior measures also suggested gradual improvement during follow-up. As measured by the problem checklist, the number of problem episodes did not increase following treatment and, in fact, a significant reduction in problem episodes was revealed over the 18-month follow-up period. Further, ratings of family and marital functioning improved during the 2 years following treatment and were significantly better than pretreatment ratings. With regard to institutional use, only one child had contact following treatment. This number represented significantly fewer children having institutional contacts than for the year prior to treatment. Further, SCIP demonstrated considerably lower costs in comparison to psychiatric hospitalization in the Houston area.

Outreach

Outreach, a community-based program for adolescents, ran a crisis line and dealt with 231 crisis situations over a 2-year period (Sawicki, 1988). Initial client contact was made by telephone during which an overview of the situation was provided and a meeting site determined--either the site of the crisis or a neutral site. During the initial meeting, Outreach workers assisted the client in determining precipitating events and developing a short-term plan of action. Intervention usually lasted for about 3 weeks and further therapy was recommended on an as-needed basis.

Data revealed that of the 231 calls dealt with by Outreach, almost 200 of those clients were deemed in need of additional therapy. Of those recommended for further assistance, 174 made appointments and kept them. Follow-up data indicated that 164 of those clients who began therapy continued to receive some form of therapy after 30 days. Of the total 231 calls, only 18 repeated during the 2-year period. Based on these findings, the author concluded that the majority of youth and families treated by the Outreach program showed signs of decreased conflict in a short period of time and displayed a greater willingness to receive assistance from more traditional types of services.

Continuous-Care Model of Crisis Intervention

Stelzer and Elliott (1990) described a continuous-care model of crisis intervention for children and adolescents in operation at the Health Sciences Center in Winnipeg, Manitoba. The model allowed the patient in crisis to be hospitalized briefly and provided continuous care for up to one year following admission. After a child was admitted, an intake meeting was arranged between the child, family, school, assessment intervention team, and other relevant agencies. Following the intake meeting, an interdisciplinary assessment was conducted and the crisis redefined based on this data. Recommendations were presented at a discharge meeting. Follow-up meetings with the family were conducted to examine the child's degree of adaptation to the discharge situation and to resolve any family problems that may have surfaced during the assessment process.

Outcome data revealed that only 8.7% of the yearly population served through the continuous-care model was readmitted. Further, measures of satisfaction indicated that parents and children reported a high degree of satisfaction with most aspects of the program.

Therapeutic In-home Emergency Services (TIES)

TIES, located in Canton, Ohio, was designed to prevent the out-of-home placement of children with serious emotional and behavioral disturbances. The program consisted of an intensive 6-week in-home intervention that provided crisis intervention and family therapy services. Pastore, Thomas, and Newman (1991) presented the results of a 3-year study designed to examine the effectiveness of the program in effecting changes in individual and family functioning and to compare these effects with programs cited in the literature.

The study involved 50 at-risk children and adolescents and their families who received an intensive six-week home-based intervention. Measures of individual and family functioning were obtained at admission, discharge, and 3 months postdischarge. Results revealed that 45 of the youngsters remained at home for the duration of the one-year follow-up period. This placement prevention rate (90%) was found to be significantly higher than rates cited in the literature. Further, an analysis of the measures of individual and family functioning found an improved level of overall functioning. These improvements were maintained at the 3-month follow-up.

Mobile Crisis Team (Child Guidance Center of Greater Cleveland)

The Mobile Crisis Team was a 24-hour program designed to reduce the unnecessary psychiatric hospitalization of children and youth through the provision of mental health crisis intervention and short-term case management services. The program also used a voucher system which allowed the family to access a range of other services. The mobile crisis unit had two overall purposes: to serve children and youth with serious emotional disturbances who were in crisis or at-risk of hospitalization and to reduce the need for institutional placement by expanding the range of available placement options. The Mobile Crisis Team strived to treat and stabilize children and youth in their community or natural environment whenever possible. Interventions ranged from telephone consultation to on-site consultation. Case management services were provided to link youth and their families to needed resources in the community.

Gazley (1991) reported the results of a comparison of the percentage of children in crisis referred for hospitalization prior to the establishment of the program and following the implementation of the program. The baseline percentage was 29%. In the first year of operation, the rate of children referred for hospitalization dropped to 6%, and in the second year, to 5%. While these findings are encouraging, conclusive statements regarding the effectiveness of the program await more rigorous research.

Youth Emergency Services (Mobile Crisis Team)

Shulman and Athey (1993) provided a description of Youth Emergency Services (YES), a collaborative mental health service in New York designed to respond to the psychiatric emergencies of children and families through a multisystem, collaborative approach. The overall goal of YES was to provide intensive services to families in an effort to reduce out-of-home placement. Through YES, children and families could begin with any one of the participating agencies and access the resources of the other agencies and the community. YES was comprised of six basic components:

1. Child Crisis Specialists who screened and evaluated all incoming referrals and linked the family to the appropriate YES component or other agency;
2. The Mobile Crisis Team, comprised of clinicians who were routed directly to the scene of the crisis where they attempted to stabilize the situation and conduct an on-site assessment;
3. Expanded Children's Services which consisted of a telephone consultation service regarding areas such as diagnosis, treatment, and medication;
4. Home-Based Crisis Intervention Services;
5. Short-term, out-of-home placement; and
6. Psychiatric hospitalization.

Data indicated that approximately 250 emergency room visits and out-of-home placements were prevented as a result of the Mobile Crisis Team component. A more extensive evaluation of the clinical and cost-effectiveness of the program currently is being conducted.

Home Crisis Intervention Program

Bishop and McNally (1993) presented outcome data for an intensive short-term, home-based crisis intervention program for children and families in Buffalo, New York. The program was designed to stabilize the immediate crisis, prevent hospitalization, and teach families new ways to resolve and prevent future crises. The program provided crisis intervention, case management, and collateral services. The latter service referred to telephone and interpersonal contacts to link the client to another agency.

A total of 46 children and families were referred to the program during 1989. Of this number, a total of 30 families completed the program as planned. Of the fifteen families responding to the inquiry made at 3 months postdischarge, none of the children were reported as having experienced a psychiatric hospitalization during this period. One year follow-up reports of eight families indicated that no psychiatric or out-of-home placements had occurred. Further, the program was found to be cost-effective in comparison to hospitalization in that the program was estimated to have resulted in a total savings of over $300,000 in hospital costs.

Conclusions and Future Research Needs

Crisis services range from residential to nonresidential settings and vary with respect to services, personnel, and agencies involved. Despite this variability, the underlying goals of most crisis programs are to begin treatment immediately, to provide brief and intensive treatment, to assist in problem solving and goal setting, to involve families in the treatment process, and to assist in the development of a network of community resources for the child and family (Stroul & Friedman, 1986).

As most crisis programs have no formal evaluation component, few studies or evaluations examining the effectiveness of crisis and emergency services have been conducted. It has been suggested that this lack of research is due to limited resources to conduct research, a lack of research-oriented crisis staff, and the nature of the crisis services which is focused on assisting those in extreme distress (Stroul & Goldman, 1990).

Based on the preliminary data gathered from the crisis programs included in the study conducted by Stroul and Goldman (1990) and the others included in this review, it appears that community-based crisis programs can serve as an effective means of reducing hospitalization and other out-of-home placements for many children. However, due to the variability among crisis programs and the differing methodologies used in the evaluation of such programs, only tentative conclusions regarding the efficacy of these programs can be made.

Most evaluations examined out-of-home placement prevention rates or the percentage of reduction in admissions to residential settings as outcome criteria. The TIES program (Pastore, Newman, & Thomas, 1991) reported a 90% placement prevention rate, and the continuous-care model of crisis intervention in operation in Winnipeg, Manitoba, related a readmission rate of only 8.7% (Stelzer & Elliott, 1990). The Children's Crisis Intervention Services (Goldman, 1988) reported that 60% of the children returned to their homes and the Children's Mobile Outreach Service (Moore, 1991) reported that 76% of the children had been diverted from hospitalization.

In addition to out-of-home placement prevention rates, a few investigations have included measures of individual and family functioning and behavioral indicators as outcome criteria. The most extensive evaluation of additional outcomes was conducted by the Systemic Crisis Intervention Program (Gutstein, Rudd, Graham, & Rayha, 1988). Results indicated that children experienced fewer suicidal attempts and aggressive outbursts during treatment and follow-up. Presenting problems were found to decrease and an improvement in adaptive behavior functioning was evident during follow-up. Problem episodes decreased during follow-up while family and marital functioning improved.

Few investigations of the cost-effectiveness of crisis programs have been conducted. Of those studies included in the present review, only three reported cost data. The costs of the Children's Mobile Outreach Program (Moore, 1991) compared favorably to those associated with institutional programs, and the Systematic Crisis Intervention Program (Gutstein, Rudd, Graham, & Rayha, 1988) was found to be lower in cost as compared to psychiatric hospitalization in the Houston area. Bishop and McNally (1993) reported that the cost of an in-home crisis intervention program in Buffalo, New York, resulted in a total savings of over $300,000 in hospital costs. Due to the small number of evaluations which have included a cost comparison component, it is difficult to draw conclusions regarding the cost-effectiveness of crisis services.

Stroul and Goldman (1990) have suggested a direction that future research may take. Additional research which evaluates the effectiveness of crisis interventions and treatment on multiple dimensions is needed as well as comparisons of different treatment approaches. Further, more research is needed which explores some of the differences between crisis-oriented, home-based services and other types of community-based crisis services and their roles within a system of care. Finally, investigations of cost comparisons and cost-effectiveness must be conducted. While the literature base regarding the effectiveness of crisis services continues to develop, initial results appear to support the expansion of such services.

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Crisis Services

Case Management Services & Individualized Care

The service needs of children with serious emotional disturbances and their families are complex and multidimensional. One of the most recent and rapidly developing methods in the effort to meet the needs of this population is case management, defined as "a mechanism for linking and coordinating segments of a service delivery system, within a single agency or involving several providers, to ensure the most comprehensive program for meeting an individual client's needs for care" (Austin, 1983, p. 16). Case management has been referred to as the "backbone of the system of care" (Stroul & Friedman, 1986) and the cohesive element that holds the system together (Behar, 1985).

In a recent newsletter, the Research and Training Center on Family Support and Children's Mental Health (1993) outlined three federal laws which highlight the recent acknowledgement of the critical role of case management in providing care to children with emotional, behavioral, or mental disabilities and their families. Public Law 99-660 required that each state develop a mental health plan for the delivery of community-based services to persons with severe mental illness. The provision of case management services was mandated for those receiving substantial amounts of public funds or services. Public Law 99-457 (Part H) introduced efforts to improve services for infants and toddlers with special needs and their families. States must provide each child and family with an individualized family service plan (IFSP), which is developed by a multidisciplinary team and contains the name of the case manager responsible for implementing and coordinating the plan. Public Law 102-321 authorized the establishment of the Child Mental Health Services Program. This effort provided grants to states, political subdivisions of states, and Indian tribes for the development of community-based and family-focused services for children with serious emotional, behavioral, and mental disorders and to establish coordinated systems of care that involve interagency collaboration among mental health, child welfare, education, and juvenile justice agencies. Case management services must be provided to all children receiving services within the system of care.

The primary role of a case manager is to ensure that needed services are delivered in an effective and efficient manner (Garland, Woodruff, & Buck, 1988). The general functions of a case manager have been outlined in the following manner:

1. assessment—an evaluation process to determine needs or problems;
2. planning—the identification of specific treatment goals and the planning of activities and services needed to achieve goals;
3. linking—the referral, transfer, or connection of the child to the appropriate services delineated in the treatment plan;
4. monitoring—consistent and ongoing contact with the child to ensure that services are being delivered and continue to be appropriate; and
5. advocacy—speaking for and representing the needs of the client to secure services and entitlements (Research and Training Center on Family Support and Children's Mental Health, 1993).

A number of case management approaches have been established. In an effort to provide a case management topology, Robinson (1991) identified four models of case management currently used for individuals with severe mental illness: the expanded broker model, the personal strengths model, the rehabilitation model, and the full support model.

Case Management Services and Individualized Care

The primary function of the traditional case manager is that of broker whose primary responsibility is to make arrangements for clients to receive services within the mental health domain. This is true also of the expanded broker model, however, as the name suggests, the focus expands beyond merely linking clients to mental health services and includes other community resources as well. The personal strengths model of case management addresses the social problems of individuals with severe mental illness. The model emphasizes the identification of the individual's strengths and strives to create situations in which success can be achieved, thus, increasing the personal strengths of the individual. Further, individuals are provided with assistance in securing community resources necessary for human growth and development. The goal of the rehabilitation model is to aid clients in meeting with success and in achieving satisfaction in the social environment of their choice with the least amount of professional assistance required. The rehabilitation model emphasizes the identification and strengthening of the client's skills as well as the identification and evaluation of skill deficits which may serve as barriers to the achievement of personal goals. Individuals are taught the necessary skills to meet their goals. The full support model of case management stresses active involvement as a means of assisting individuals with mental illness to make improvements in their level of functioning in the community and to reduce symptomatology. Case management practices involve teaching clients an array of coping skills and providing support to clients in the community.

Effectiveness and Outcome Research

The isolated contribution of case management services to the overall effectiveness of a system of care is difficult to determine. However, it is possible to examine the effectiveness of an individualized continuum of care, which relies on the provision of case management services to "integrate treatment programs and facilitate transitions between services" (Bickman, Heflinger, Pion, & Behar, 1992, p. 854). Studies documenting the effectiveness of case management with adult populations are available (see Biegelow & Young, 1991; Chamberlain & Rapp, 1991; Intagliata & Baker, 1983; Rubin, 1992; Solomon, 1992). The adult literature has been useful in providing direction for the development of case management services for children and the identification of factors that affect case management services, such as size of caseloads and financing. However, these findings must be viewed with caution as the service and developmental needs of children with emotional and behavioral problems and their families differ significantly from those of adults with mental disorders.

A number of case management programs have been developed nationwide to serve children with special needs. However, due to the difficulty in evaluating the separate contribution of case management services to the overall effectiveness of a system of care, there is a virtual absence of well-controlled studies in the field of children's mental health (Burns & Friedman, 1990). Studies investigating the effectiveness of case management programs for children with serious emotional disturbances are just being published (e.g., Lemoine, et al., under review; Burns, Gwaltney, & Bishop, in press). The following section reviews recent evaluations of case management services for children with serious emotional disturbances in New York as well as evaluations investigating the effectiveness of case management services for populations of children with special needs other than serious emotional disorder.

Case Management Services for Children with Serious Emotional Disturbance

New York

Evans, Banks, Huz, and McNulty (in press) described New York State's Intensive Case Management Program for Children and Youth (CYICM). The case management model is best described as an Expanded Broker Model (see Robinson, 1991, for a description of this model). The case management program was an intensive, client-centered, linkage and advocacy-focused model of case management which has been implemented in 42 counties in the state. Case managers had small caseloads (10:1) and provided assessment, planning, linking, and advocacy services. The primary goal of CYICM was to place children with serious emotional disturbances in the least restrictive environment appropriate to their needs. Data on the effectiveness of case management in preventing hospitalization and increasing community tenure is presented below.

Data were gathered from a Client Description Form and the Department of Mental Hygiene Information System which tracks the movement of all persons within the state psychiatric hospital system. Two analytic techniques were used to assess effectiveness. A pre/post matched case community tenure analysis was conducted to examine whether length of stay in the community between admission to the state psychiatric hospital following CYICM enrollment was significantly longer than the time observed between hospital stays for the same cases in the pre-enrollment period. A sample of 87 children was included in the analysis. Results revealed that post-enrollment time intervals between admissions were longer after CYICM (average of 574 days) than prior to receiving this service (average of 122 days).

An analysis of patterns of state psychiatric hospital utilization was also conducted. This analysis involved a pre/post intervention comparison of utilization levels and was conducted to determine whether the observed changes in inpatient utilization were due to enrollment in CYICM. The analysis was conducted using a sample of 526 children. Results revealed that system utilization shifted to a lower level following CYICM enrollment. Overall, the data suggested that CYICM was associated with fewer hospitalizations, fewer hospital days, and more days spent in the community following enrollment as compared to pre-CYICM enrollment of children with serious emotional disturbances.

Evans, Armstrong, Dollard, Huz, Kuppinger, and Wood (under review) presented the preliminary findings of another study of New York's intensive case management model for children and youth with serious emotional disturbances. Under controlled experimental conditions, children referred for therapeutic foster care in three rural New York counties were randomly assigned to groups receiving Family-Centered Intensive Case Management (FCICM) services or Family-Based Treatment Foster Care (FBT) services. FCICM was a community-based program designed to empower and support the families of children with serious emotional disturbances. Utilizing a case manager and parent advocate, the FCICM intervention included respite, flexible service money, parent support groups, and parent skills training. FBT was New York's treatment foster care program which was designed to provide the least restrictive placement for children with serious emotional disorders who necessitated treatment in an out-of-home setting. The program provided training, support, and respite to professional families which allowed the child to be cared for in a family-based setting. When possible, children were reunited with the biological family after treatment goals were achieved.

Assessments of child and family functioning were conducted at referral, every 6 months during treatment, and at 6 months post-discharge. Preliminary six month data were available for 22 children and families. Six month data focused on measures of family functioning, child symptomatology, and changes in services needs. For the entire group, as well as by program type, the level of unmet need either decreased or remained unchanged, except in the area of recreation. Across interventions, the greatest decreases in service needs were in the areas of education and mental health. While all children in the FCICM group were in need of recreational services at admission and at 6-month follow-up, there was a decrease in need from admission to six months for 45% of the children in the FBT group.

The Parent Skills Index (Magura & Moses, 1986) was utilized as a measure of family functioning. For parents in both the FBT and FCICM groups, there was a slight but positive change on four of the six scales from admission to 6 months (Motivation to Solve Problems, Approval of Children, Consistency of Discipline, and Teaching/Stimulation of Children). There was a slight decrease on the Recognition of Problems and Acceptance/Affection for Children scales. In a comparison of FBT and FCICM parents, FBT natural parents improved or maintained their scores on all six scales from admission to 6 months. Results for the FCICM parents were mixed. Scores increased on three scales and decreased on the other three scales. FCICM parents had better scores than FBT parents on the Consistency of Discipline and the Approval of Children scales.

Scores on the Child and Adolescent Functional Assessment Scales were significantly improved in the areas of Role Performance and Moods/Emotions. Further, the mean number of problem behaviors and symptoms as measured by the Child Behavior Checklist (Achenbach, 1991) decreased for both groups between admission ($X = 5.4$) and 6 month follow-up ($X = 3.6$) (personal communication, Mary Evans, February 14, 1994). The authors stated that the lack of dramatic change or differences in outcomes across conditions was expected because findings are based on 6 month outcomes only. Greater differences between the two conditions are expected following analysis of long term data.

Case Management for Other Populations of Children

Developmental Disabilities

Singer, Irvin, Irvine, Hawkins, and Cooley (1989) conducted a study of the families of children with severe developmental disabilities. Families were randomly assigned to one of two groups: 1) *modest service*, which consisted of the provision of respite care and case management services or 2) *intensive service*, which consisted of stress management, parenting skills training, support groups, and community-based respite care. A significantly greater number of parents in the intensive services group achieved clinically significant improvement on measures of anxiety and depression. These findings suggested that the provision of comprehensive services provided directly to families was more effective than the provision of case management and respite services alone.

Drop-out Prevention

Stowitschek and Smith (1990) described the development and implementation of an interprofessional case management model (C-STARS) for drop-out prevention programming in school-community sites in Washington State. The model was comprised of four components:

1. the directing and development of case management services;
2. generic case management functions which included the identification and assessment of students, advocacy efforts, the development of a service plan, the brokering of services, the implementation of a service plan, mentoring, and evaluation and tracking;
3. special implementation considerations which pertained to program quality, equity, and comprehensiveness; and
4. a university interdisciplinary team which provided technical assistance, training, and other support services.

The following instruments were used to evaluate the effectiveness of C-STARS: checklists which assessed the status of case management implementation and reviewed program status; monthly student progress updates; individual service plans/checklists which documented the development, implementation, and impact of individual service plans for at-risk students; and screening charts to record student progress on selected risk factors, such as attendance and school conduct. Team member and consumer opinionnaires also were completed.

Nine school-community sites participated in the project. First year results of a formative evaluation of the C-STARS case management model revealed that sites reported that at least 85% of the generic elements of interprofessional case management had been implemented for at-risk students. Individual service plans had been completed for a total of 87 students. *All* service goals had been attained for 35% of these students, and 68% had attained at least one service goal. Moderate changes were reported for three targeted risk measures: the percent of students whose absences exceeded 10 or more days per semester decreased from 73% to 40%; the number of students earning one or more unacceptable grades decreased from 82% to 54%; and the percentage of students receiving one or more days of poor conduct reports decreased from 95% to 71%. The most significant outcomes reported by case managers were graduation of students, increased participation in school, and higher levels of family involvement. Thus, the C-STARS model of case management appears to have played a critical role in the reported positive outcomes for the population of students at-risk of dropping out of school.

Homeless

Stoep and Blanchard (1992) reported the findings of the evaluation of a mental health case management service program for homeless youth in (King County) Seattle, Washington. Case management services were delivered to homeless youth through a licensed mental health agency for a period of nine months. The multi-service center provided meals, recreation, counseling, health screening, a school program, and referrals to local agencies for homeless and street youth who had not successfully been served by traditional mental health services. Further, an attempt was made to increase the clients' opportunities to return to their home by offering services to the family. Case plans were developed collaboratively by an interdisciplinary treatment team, the youth, and the family. Treatment outcomes for two groups were based on data gathered from screening/intake forms, service logs, and interviews with case managers. The client group (n = 28) was comprised of youth who were provided with a mental health case manager and received services, while the contact group (n = 48) included youth who had some contact with mental health case managers but did not complete the intake process. For the total 76 youth who had contact with case managers during the project (October 1990-February 1992), desirable outcomes were achieved in the six areas assessed: 11 youth were returned to their local community, 17 were linked with resources to work with parents, and 16 were assisted in reentering entitlement or treatment programs. Nineteen youth were assisted in gaining placement in a house or shelter. Ten youth were helped to obtain job training and eight received a GED. On average, about 14% of all the youth returned to their local community.

A comparison of the two groups revealed that a higher percentage of youth in the client group achieved the desired treatment outcomes as compared to youth in the contact group. For the client group, over 32% achieved the outcomes of working with parents, securing shelter, and obtaining entitlement, while a smaller percentage of those in the contact group achieved these same outcomes (17%, 21%, and 15%, respectively). About 14% of the youth in the client group obtained a GED, while approximately 8% did so in the contact group. Greater than 20% of those in the client group were received job training, as compared to about 8% of the contact group.

Recently, an evaluation of an innovative, intensive case management program for homeless adolescents in Seattle, Washington, has been undertaken by Cauce and her colleagues. This innovative program differs from services "as usual" in that case load size is limited to 12 youth, the amount of supervision and the resources made available to case managers is increased and the educational levels of case managers are higher than case managers providing services "as usual." Analysis of data collected during the first three months of the program indicate that for self-reported levels of aggression, general externalizing behavior, and satisfaction with quality of life, there was a trend for youths assigned to the innovative program to improve more than youth in regular case management services (Cauce et al., in press).

At-Risk

The SUCCESS program, implemented in the Des Moines (Iowa) public school system, was developed to provide services to children and families at-risk of not achieving the goals of their educational programs or thriving in their families and/or communities. Community resources were integrated within the school system through the use of family resource centers.

The SUCCESS program was based on the following strategies:

1. the provision of case management services to targeted families;
2. the location of human services staff in the schools; and
3. the provision of referral and intensive follow-up services.

Findings are derived from the first formal evaluation of services and outcomes based on 270 children and youth. According to the planning/evaluation report for 1990-1991 (Des Moines Public Schools, 1991), students receiving case management services made progress in the areas of attendance, grade point averages, reduced suspensions, re-enrollment of drop-outs, participation in extracurricular activities, and family environments. Further, reactions from parents and students were positive and services were perceived as helpful. A more rigorous evaluation of program outcomes is planned.

Developmental Disabilities and Health Problems

Marcenko and Smith (1992) reported the findings of a study which examined the impact of a family-centered case management approach for the families of children with both a developmental disability and a chronic health condition. Mental retardation and cerebral palsy were the most frequent developmental disabilities, while chronic health conditions varied among mucopolysaccharidosis, diaphragmatic hernia, and bronchial pulmonary dysplasia. A family-centered case management program focuses on the "family as a constant in the child's life and thus emphasizes parent/professional collaboration, and the responsiveness of the service system to family needs" (Marcenko & Smith, 1992, p. 90). Projects were based on a services management model with the goal of providing services to increase the potential of the person with a disability and his or her family in the areas of independence, productivity, and community integration. Strategies implemented to meet this goal included outreach, coordination, brokering, monitoring, advocating, training, and interdisciplinary team planning. Primary activities of project staff included working with parents in groups, arranging for support services, obtaining financial assistance for services, counseling, and administration. Service plans were developed in collaboration with the family, social workers, school personnel, and medical professionals. Interventions were conducted with families in their homes, the hospital, schools, and at the social service agency.

Data (N = 32 families) were gathered during the first month of participation in the project and approximately one year later. Measurement instruments included a semi-structured questionnaire designed to evaluate program impact and an intake instrument which gathered information on socio-demographics, service utilization and satisfaction, family stress and coping, and maternal life satisfaction.

The assessment of the impact of the case management program was based largely on service needs assessment and changes in service use. The most significant increases in service use were in the areas of regular respite care and home nursing. Small increases also were noted in the frequency with which families used education services, child care training, transportation to school, and routine medical services. Families continued to indicate a high level of need for recreational activities, life planning services, legal services, regular day care, and speech therapy.

Data regarding program effectiveness were gathered by asking mothers to identify the ways in which they had benefited from services provided by project staff. Mothers noted the following benefits: greater access to services, assistance with the financing of services, opportunities to become involved with and to receive emotional support from other families and staff, information about caring for their child, and the development of advocacy skills. Mean ratings of maternal satisfaction with current life situation, as measured on a ten-point Likert scale, revealed a statistically significant increase from intake (5.39) to follow-up (6.25). Further, a five-point Likert scale was used to measure the coping ability of siblings without handicaps. Findings revealed a nonsignificant but slight decrease in the mean ratings of coping skills of siblings without handicaps between intake (2.41) and follow-up (2.77) indicating that the coping skills of siblings without handicaps tended to decrease. Thus, the findings indicated that family-centered case management services were beneficial to families, particularly in the areas of accessing existing services and increasing maternal life satisfaction. It should be noted, however, that no control group was used. Thus, it is not known if the same gains would have been experienced in the absence of case management services.

Chapter Seven

Substance Abuse

Muller et al. (1992) reported the results of a demonstration project designed to develop and investigate innovative interventions for children at high risk for substance abuse disorders in the state of Alabama. Participants in the project consisted of 171 youth and their families who met at least two of seventeen risk factors deemed to be related to substance abuse. Participants were placed in one of two intervention groups: Case Management Intervention (n = 112) or Home-Based Intervention plus Case Management Follow-up Services (n = 59). Those who were at imminent risk for removal from the home were targeted for the more intensive home-based intervention group. Children placed in the Home-Based Intervention plus Case Management Follow-up group received 3 months of home-based intervention followed by one year of case management follow-up services. A two member team worked with families in their homes for about two, 2-hour sessions on a weekly basis throughout the 3 month intervention period. Services were family-focused and ecologically-based and included outreach services, crisis intervention services, family training and counseling, modeling, and individualized goal contracting. During follow-up, case managers functioned in the areas of linking families to services, advocacy, information dissemination, referral, and monitoring. Those in the Case Management Intervention group received 15 months of case management services only. The duties of the case manager consisted of outreach, service planning, service linking, advocacy, information dissemination, referral, and monitoring.

At pretest and posttest, children and their families were administered a battery of instruments to measure service needs and functioning. Assessment instruments included the Service Utilization and Needs Assessment Instrument which measured the need for socialization/recreation, education, daily living skills training, transportation, financial, medical, mental health, and housing services. The Environmental Deprivation Scale was administered to assess the client's level of adaptive functioning in the following areas: educational/school activities, leisure time activities, interpersonal interactions, and self-management behaviors. The Maladaptive Behavior Record was used to identify specific maladaptive behaviors. Parenting skills and other adaptive parent characteristics were assessed via the Parent Input Index for both the mother and father. The Drug

Evaluation Scale and the Alcohol Evaluation Scale were used to determine alcohol and drug use for each client. At baseline, median total scores on all measures were similar across the groups for both interventions and were indicative of severe maladaptation on all assessment instruments. Further, baseline outcome measures were similar for both groups.

Results revealed two major findings. First, families who participated in the intervention for more than 9 months improved in all areas of functioning as compared to those who participated 3 to 11 months. In other words, those families and children who had maintained a longer relationship with service providers fared better in all areas of functioning. Further, families who refused to participate or dropped out of the intervention after receiving minimal participation experienced fewer improvements in functioning and, in fact, exhibited some declines in functioning over time. A second significant finding revealed that the group receiving Home-Based Intervention plus Case Management Follow-up Services showed greater improvement in all areas of functioning, with the exception of alcohol and drug abuse, as compared to the Case Management Intervention group. For both intervention groups, the greatest improvements were in the areas of meeting needs for community services and increasing service utilization. Thus, these results suggested that both the Case Management Intervention and Home-Based Intervention plus Case Management Follow-up Services were effective interventions for families with youth at high risk for substance abuse. However, the limited effect of these interventions on alcohol and drug abuse suggested that these particular behaviors may be the most resistant to change and may be the last to change. Further studies utilizing a more rigorous, controlled research design are needed.

Evans, Dollard, and McNulty (1992) described the characteristics of youth with and without substance abuse being served in New York State's Intensive Case Management Program for Children and Youth (CYICM) and their use of inpatient services before and after enrollment in CYICM. As described in the previous section, the case management program in New York was a client-centered, linkage and advocacy-focused model of case management which had been implemented in 42 counties across the state. Case managers had a small caseload (10:1) and services were delivered in natural settings.

A total of 664 adolescents were served by CYICM and 145 (22%) of this total number were defined as substance abusers. Criteria for classification as a substance abuser included a history of alcohol or substance abuse treatment, a DSM-III-R alcohol or drug diagnosis, the display of symptoms of alcohol or drug abuse upon enrollment in CYICM, or a referral for alcohol or substance abuse treatment upon discharge from CYICM. For the purposes of this review, only results pertaining to the effects of CYICM in reducing residential placement are presented (see Evans, Dollard, & McNulty, 1992, for a review of the characteristics of this population). To measure the effectiveness of CYICM in the prevention of unnecessary restrictive placement, change in the living situation of youth between admission and discharge was assessed. Environments were rank-ordered based on level of restrictiveness, i.e., independent living rated as least restrictive to institutional living rated as most restrictive. For both the substance abusing and non-substance abusing groups, living situation at discharge from CYICM was significantly different from the living situation at admission. For the group of substance abusers (*N* = 52), 73% had no change in living situation between admission and discharge, 4% moved to a less restrictive placement, and 23% moved to a more restrictive placement setting. Of the non-substance abusing group (*N* = 140), 68% had no change between admission and discharge, 8% moved to a less restrictive setting, and 24% moved to a more restrictive placement.

A reduction in the number of hospital admissions and days spent in inpatient settings was used as another measure of the effectiveness of preventing unnecessary restrictive placement. Data for the 12 months preceding admission to CYICM and the 12 months following admission to CYICM were analyzed for a total of 157 youth. No significant differences were noted in the average number of state inpatient admissions between the groups in either the 12 months preceding or following admission to CYICM. However, within group comparisons of the pre- and post-enrollment periods revealed that the average number of admissions was significantly higher in the pre-admission period for both groups. With regard to the number of days spent in inpatient settings, a within-group comparison of the pre- and post-enrollment periods indicated that the average number of days spent in state hospitals was significantly higher in the pre-enrollment period for both groups. No significant difference was noted between the two groups in post-admission length of stay (27 vs. 14 days); however, non-substance abusers spent significantly more days on average in state hospitals during the pre-enrollment period (82 vs. 53 days). Further analysis revealed no significant difference between the groups in the reduction of average inpatient days from pre- to post-enrollment periods. Thus, the CYICM intervention was not more effective for one group than the other in reducing the number of days spent in the hospital in the post-admission period. The authors concluded that the CYICM intervention was associated with a decrease in hospital admissions and total number of days spent in inpatient settings following admission to CYICM for all youth, including those with substance abuse problems. Results should be viewed with caution due to the absence of a comparison group.

Individualized Care

Another important characteristic within a system of care is the principle of individualized care. Based on the results of a thorough assessment of the child and the family, individualized programs are "custom designed" or tailored to meet the individual needs of each child and his or her family (Burns & Friedman, 1990). Individualized care has been characterized by the key elements of case management/ case coordination, wrap around services, flexible funding and services, interagency collaboration (Katz-Leavy, Lourie, Stroul, & Zeigler-Dendy, 1992), unconditional care, least restrictive care, and child and family-centered care (Burchard & Clarke, 1990).

Although the concept of individualized care was one of the original Child and Adolescent Service System Program (CASSP) values (Stroul & Friedman, 1986), it has taken a considerable period of time for this concept to be incorporated into actual practice (Research and Training Center for Children's Mental Health, 1988). Brief descriptions and available outcome data of current approaches to the delivery of individualized services to children with serious emotional disturbances and their families are provided.

North Carolina

One of the first systems of care to incorporate the concept of individualized care was developed in North Carolina (Behar, 1985). In response to a lawsuit, the state of North Carolina developed the Willie M. Program, a well-funded, full range of community-based services for children and adolescents with severe emotional, neurological, or mental handicaps and who are violent or assaultive.

Chapter Seven

A recent evaluation of the Willie M. Program was conducted by Weisz and his colleagues. Weisz, Walter, Weiss, Fernandez, and Mikow (1990) conducted a pre/post-test comparison of time of first arrest for two groups of individuals who were emotionally disturbed, violent, and assaultive. The short-certification group (*n* = 21) was comprised of individuals who had received services through the Willie M. Program for less than 3 months, while individuals in the long-certification group (*n* = 147) had received services for more than one year. Groups were comparable on demographic characteristics, problem behavior histories, IQ, diagnosis, and age at earliest antisocial act. The results of a survival analysis revealed that the long-certification group showed a somewhat more favorable survival curve than the short-certification group; however, this difference did not reach statistical significance. Thus, these findings do not appear to provide strong support for the reduction of risk of later arrest among violent and assaultive youth following participation in the Willie M. Program. The authors suggested a number of reasons for these findings. Arrest data may not serve as the most sensitive indicator of success for the program. Further, no true control group exists for the comparison of individuals receiving services through the Willie M. Program. Also, these findings are based on data gathered during the early years of the program and may not reflect the current functioning and therefore, effectiveness of the program.

Kaleidoscope, Inc.

Kaleidoscope is a licensed, not-for-profit child welfare agency founded in 1973 to serve as an alternative to institutional placement for the most-in-need children and youth in Illinois (Kaleidoscope Program Materials, n.d.). The philosophy of the agency is based on two concepts: normalization and unconditional care. The concept of normalization is based on the tenet that children who live and learn in a normal environment (family, neighborhood, community) have a greater opportunity to develop into normal, competent adults. Unconditional care rests on the premise that children need loving care regardless of their behavior and that a lack of care worsens their situation and leads to additional burdens to society. An individualized service plan was developed for each child and a treatment program was tailored to meet the specific needs of the individual child. The Kaleidoscope program was comprised of three basic program models: 1) Therapeutic Foster Family Homes Program, in which professional foster parents are paid and trained to provide full-time care; 2) Youth Development Program, which provided placement and supervision to older youth living in apartments in the community to assist them in making the transition to self-sufficiency; and 3) Satellite Family Outreach Program, which was a family-based program that strived to successfully reunite children in residential treatment with their families and to prevent the unnecessary placement of children in out-of-home settings. Thus, a continuum of care existed which allowed children to move from program to program as their needs and circumstances changed. To date, no empirical investigations of this model of individualized care have been conducted; however, cost data revealed the substantial cost savings of these individualized programs as compared to restrictive, residential placements (Kaleidoscope Program Materials, n.d.). Currently, the efficacy of the Kaleidoscope program and other innovative, community-based, child- and family-focused service programs are being empirically investigated (see Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993)

Alaska Youth Initiative (AYI)

AYI represents the most comprehensive example of individualized care (Burchard & Clarke, 1990). The Alaska Youth Initiative, adapted from the Kaleidoscope program in Chicago, used individualized care to return children with severe behavioral and emotional disorders from out-of-state, residential programs. The demonstration project, conducted between the years of 1986-1991, was created to provide individualized, community-based, wraparound services to children with severe emotional disturbance.

Burchard, Burchard, Sewell, and VanDenBerg (1993) reported the results of a qualitative case study evaluation of ten youth deemed to be among the most difficult-to-serve children and youth in Alaska, that is, children and youth for whom all available alternatives to long-term residential treatment had failed. Qualitative data were gathered through record reviews and structured interviews with service providers, families, and youth.

A qualitative analysis of the cases revealed that for nine of the ten cases, AYI served as a successful alternative to long-term residential treatment. For six of the ten cases, children and youth were successfully reintegrated and socialized in their own or nearby community following discharge from restrictive residential placement. During their participation in

AYI, nine were assisted in becoming more independent and responsible, socially appropriate, and acceptable to themselves and their communities.

At the time of the study, nine youth had lived in open settings in their respective communities from 1 to 3 years. These settings included the home of the parents, apartments in the community, supervised apartments, and therapeutic foster care. Five of the eight older youth had been discharged from AYI and were living in the community. In interviews conducted at 6 months post-discharge, four of the eight older youth reported that they were confident of their ability to continue to live unsupervised in the community. The remaining five children and youth were still receiving active treatment through AYI. Two of the children were in specialized foster homes and regular school placements. The remaining three had returned from restrictive, lengthy institutional placements and had received community-based services for 3 to 12 months.

With regard to educational outcomes, three of the children that were in school at the time of the evaluation had been reintegrated successfully in mainstream schools and classes for most or all of their course work, and two of the three children were receiving high marks on a consistent basis. Five of the older youth had either successfully graduated from high school or had obtained a GED. Based on this qualitative evaluation, it appears that the provision of individualized care through the AYI model proved effective in serving as an alternative to restrictive residential treatment for a sample of the most challenging youth in Alaska.

Vermont

Clarke, Schaefer, Burchard, and Welkowitz (1992) reported the findings of an evaluation of Project Wraparound, a three year demonstration project in which individualized care was used to prevent the placement of children in out-of-home settings. Project Wraparound was a community-based individualized treatment program in Vermont which provided intensive home- and school-based services to children and youth with severely maladjusted behavior and their families.

The purpose of the evaluation was to determine whether children who received wraparound services experienced a decrease in behavioral symptomatology in home and school settings as indicated by measures of child and family adjustment. A total of 19 families and their children comprised the sample used in the analysis of home data, while an additional 12 children were included in the analysis of school data.

Measures of child adjustment included the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983), the Teacher Report Form (TRF; Achenbach & Edelbrock, 1986), the Self-Control Rating Scale (SCRC; Kendall & Wilcox, 1979) and the Connors Hyperkinesis Index (CHI; Goyette, Connors, & Ulrich, 1978). Measures of home environment included the Child Well-Being Scales (CWBS; Magura & Moses, 1986). Results of child adjustment measures indicated a significant improvement in child behavioral adjustment during the 6-month intensive home intervention period, with increased improvement over the course of the year. Improvements in behavior were not achieved in the school setting. Results of the CWBS (home environment) indicated a highly significant positive change on Composite and Parental Disposition scores; however, results for the Household Adequacy and Child Performance Subscales were not significant. Thus, Project Wraparound appears to have been effective in the improvement of child and family functioning in the home setting; however, there was no evidence of behavioral improvements in the school setting. The authors suggested a number of possible explanations for these findings, i.e, schools provided poor psychological services, schools were not receptive to the practice of mainstreaming children with serious emotional disturbance, and mainstreaming may not be the most effective method for improving the behavior of some children with serious emotional disorders. Another explanation for these findings was the use of a small sample size.

Rosen, Heckman, Carro, and Burchard (1994) examined client satisfaction as an outcome for youth ($N = 20$) who received community-based, wraparound services in Vermont. Youth were queried about their satisfaction with services, their sense of involvement, and their feelings of unconditional care[1]. Results found that sense of involvement and perception of unconditional care were strongly associated with satisfaction with services and service providers. Neither satisfaction nor involvement were associated with the severity of the youths' behavior. The perception of unconditional care had a strong, negative association with the severity of the youths' behaviors. The authors concluded that although the relationship between satisfaction and behavioral adjustment remains equivocal, the youths' perceptions of unconditional care does appear to contribute to behavioral adjustment.

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[1] Unconditional care is defined as "the youth's sense that his or her caretakers would remain stable regardless of what happened" (Rosen, Heckman, Carro, & Burchard, 1994, p. 55).

Conclusions and Future Research Needs

The provision of case management services is a recent and rapidly developing effort aimed at meeting the complex and multidimensional needs of children with serious emotional disturbance and their families. The primary role of the case manager is to ensure that services are delivered in an effective and efficient manner. A number of case management models currently exists. Approaches range from those in which the case manager acts as a broker with the primary responsibility of making arrangements for clients to receive services, to a full support model in which the case manager provides specific clinical tasks in addition to the brokering of services.

Little research has been conducted to determine the effectiveness of case management services for children with serious emotional disturbances and their families. This paucity of research stems from two primary factors: 1) the separate contribution of case management services to the overall effectiveness of a continuum of care is difficult to determine and 2) the recency of the provision of case management services to children with serious emotional problems and their families. The most recent efforts to examine the effectiveness of case management services for children with serious emotional disturbance and their families have been conducted in New York. A study conducted by Evans, Banks, Huz, and McNulty (in press) examined the initial hospitalization and community tenure outcomes of intensive case management. Overall, the findings revealed that the provision of case management services was associated with fewer hospitalizations, fewer hospital days, and more days spent in the community. The study conducted by Evans, Armstrong, Dollard, Huz, Kuppinger, and Wood (under review) examined the effectiveness of two intensive community-based programs for children with serious emotional disturbance and their families: Family-Centered Intensive Case Management (FCICM) services and Family-Based Treatment Foster Care (FBT) services. Preliminary 6-month data found no dramatic change or differences across the two conditions in the areas of service needs, family functioning, and child symptomatology. Greater differences are expected when long-term data are analyzed.

A greater number of studies has been conducted which examined the efficacy of case management services for children with special needs other than serious emotional problems. The studies reviewed in the current paper included a variety of populations, such as children with developmental disabilities and chronic health conditions, homeless children and youth, at-risk children and youth, and youth with substance abuse problems. The results of these studies revealed generally positive outcomes for those receiving case management services.

The principle of individualized care calls for the delivery of services which meet the unique needs and potentials of each individual child and family. As was true for the area of case management, little research has been conducted to examine the effectiveness of individualized care. This is perhaps due to the great variability in the types of problem behavior exhibited by the children served and consequently, no two children received the same array of services. Four programs which have incorporated the principle of individualized care for children and youth with serious emotional disorders were reviewed. The results of data examining the effectiveness of individualized care were mixed. The evaluation of the Willie M. Program in the state of North Carolina did not provide strong support for the reduction of risk of later arrest among violent and assaultive youth following participation in the program. In contrast, a qualitative analysis of 10 youth who participated in the Alaska Youth Initiative revealed that the provision of individualized care through the AYI model was effective in serving as an alternative to restrictive residential treatment for a sample of the most challenging youth in Alaska. Findings from an evaluation of Project Wraparound in Vermont indicated the effectiveness of the program in improving child and family functioning in the home setting; however, behavioral improvements did not generalize to the school setting.

Based on the limited research available, it appears that the provision of case management and individualized care services are promising approaches in meeting the complex needs of a portion of children and youth with serious emotional problems and their families; however, definitive conclusions regarding effectiveness can not yet be drawn. Thus, future research in these areas is greatly needed. Burchard and Clarke (1990) suggested a number of ways in which future research can investigate the effectiveness of individualized care. First, single subject designs, in which children act as their own controls, can be utilized to examine the effectiveness of individualized care. Second, studies can incorporate an experimental group design which compares the outcomes of children who have been randomly assigned to either individualized care or component care. Lastly, children in a community which provides individualized care can be compared to a matched group of children in a community in which individualized care is not available.

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Chapter Seven

Family Support Services & Family Support Groups

The field of children's mental health is experiencing a "quiet revolution" in the design, delivery, and evaluation of services for children with emotional, behavioral, or mental disorders and their families (Friesen, 1993). This period of transition has been described as "a shift in both conceptualization and practice" (Duchnowski & Kutash, 1993, p. 2). This evolving mental health service delivery system for children and families is characterized by a number of factors, one of which is the full participation of families in every phase of the treatment planning process instead of the historical practice of blaming families for the problems experienced by their children (Knitzer, 1993). A variety of programs and services have been developed in an effort to meet the goal of fully involving families in the treatment planning process for their children and to provide support as families take on this new role. The purpose of this paper is to review the literature on the effectiveness of family support services for the families of children with special needs, in particular those with serious emotional disabilities, as well as the outcomes associated with participation in self-help or support groups.

Chapter Eight

Family Support Services

Along with this emerging role of the family is the acknowledgment of the need to develop "family support services," which are designed to assist families of children with disabilities in meeting their emotional, social, and basic needs. These families face a number of issues beyond those of families of children who do not have special needs. Modrcin and Robinson (1991) described the potential effects on the family of a child with a serious emotional disturbance as: (1) disruptions in communication patterns, family roles, and patterns of daily living; (2) unpredictability of the child's cognitive and emotional development; (3) a sense of loss as the expectations of the parents fail to be commensurate with the abilities of the child; (4) concerns of long term care and support which alter the roles of the parents and siblings; and (5) the need for additional coping strategies and resources for the management of stress. These issues that confront the families of children with serious emotional disturbance clearly illustrate the need for increased attempts to provide families with needed support.

"Family support is doing whatever it takes to make it possible for families that include members with disabilities to just be families" (Agosta, 1992, p. 4). The primary goal of family support services is "to keep families together and to help all family members to achieve balanced lives" (Friesen & Wahlers, 1993, p. 12). Until recently, the concept of family support services was restricted to the provision of respite services, i.e., providing a period of relaxation to the parents or child. Currently, services within the realm of family support may include "family self-help, support and advocacy groups and organizations; information and referral; education that will support families in becoming active, informed decision-makers on behalf of their family and the child; advocacy with and on behalf of the family, if needed; the capacity to individualize, provide flexible support services, and meet unplanned needs quickly and responsively; in-home and out-of-home respite care, with an emphasis on neighborhood and community participation for the child and conceptualized not as a clinical service but as a support for the whole family; cash assistance; assistance with family survival needs (housing, food, transportation, home maintenance, etc.); and other supports, as determined by the family" (Federation of Families, 1992, p. 1). A substantial amount of support and assistance is essential for families of children with special needs as their difficulties often are related to the emotional, physical, social, and financial stresses inherent in the care of a child with serious emotional disorders. Since 1984, when the first local level parent-run groups began forming, significant progress has been made in the organization of parent support efforts (Friesen & Koroloff, 1990). The first local parent run organization for families of children and adolescents with emotional disturbances was the Parents Involved Network (PIN), sponsored by the Mental Health Association of Southeastern Pennsylvania. This organization provides a number of parent support services, including support groups, telephone information, newsletters, referral services, and advocacy training (Karasik & Samels, 1990). PIN provided a model for other parent-run organizations to follow; as a result, a number of similar programs have emerged across the country.

Effectiveness and Outcome Research: *Family Support Services for Families of Children with Serious Emotional Disturbances*

Research on the effectiveness of family support services and/or family support programs for families of children with emotional disabilities is scarce (Friesen & Koroloff, 1990; Zigler & Freedman, 1987). However, some evaluative studies have been conducted to assess the benefits of family support services for families of children with emotional disturbances as well as other special needs. In a brief review of these studies, Friesen and Koroloff (1990) stated that a considerable research base existed for family support services designed for the purposes of prevention and early intervention services with children and families who are at risk, as well as services provided to families of children with a variety of disabilities. The positive effects of these family support services have been shown primarily in the areas of specific services such as respite care and the use of social support systems. The benefits of respite care included positive benefits for siblings, a reduction in the family's sense of isolation, and decreases in the incidence of child abuse and neglect. Parent support groups have been found to result in increased access to information and improved problem-solving abilities for a portion of parents. Further, family members have been found to hold more positive attitudes, take a more optimistic outlook on parenting, and hold a more positive view of their children's behaviors (see Friesen & Koroloff, 1990). Outcomes for specific family support programs which provide resources to families of children with a variety of special needs, including emotional disabilities, are provided in the following sections.

Agosta (1992) reported the results of evaluation studies of family support services in two states. The determination of effectiveness was based on placement preference and meeting family needs. The placement preferences of the families participating in four pilot programs in Illinois were examined. Results revealed little overall change in placement preference over time; however, few families preferred an out-of-home placement for their child *before* receiving family support services. To assess whether or not family support services were effective in meeting family needs, evaluations of pilot programs in Illinois and a statewide program in Iowa were conducted. Evaluation results revealed that families reported a high degree of satisfaction with the family support programs and reported that the programs had a favorable impact on various family life domains. Although families indicated that a great many needs were left unmet, results revealed a significant reduction in family needs in those areas specifically addressed by the family support program.

The Finger Lakes Family Support project, a professional family-support program for families of children with emotional problems, operates as a collaboration between professionals and family members in nine rural counties in the Finger Lakes area of New York State (Friesen & Wahlers, 1993). The project consists primarily of three major components: family-support groups; child care and respite care; and conferences, family retreats, and training opportunities. An evaluation of the program revealed that many parents felt that the project assisted them in decreasing stress, increasing their ability to cope and to help themselves, and keeping their children at home. Further, stress associated with parenting and the parents' perception of the severity of their children's problems decreased over time (Murray, 1992).

Effectiveness and Outcome Research: *Family Support Services for Other Populations*

Telleen, Herzog, and Kilbane (1989) examined the impact of a family support program on the social support, depression, parenting stress, and perceptions of children in mothers ($N = 38$) with children under the age of seven years. One group ($n = 16$) participated for three months in a support group for mothers, while another group ($n = 22$) took part in a parent education class for three months. A matched control group ($N = 23$) was comprised of mothers who used a medical clinic for the pediatric care of their children. After the 3-month period, mothers in both treatment groups reported feeling less social isolation and parenting stress than those in the control group.

Reis, Bennett, Orme, and Herz (1989) conducted a quasi-experimental evaluation of three demonstration family support programs implemented in 1982. The primary goal of each of the family support programs was to reduce the rate of child abuse and neglect on a community-wide basis. Respondents included a total of 365 mothers who participated in the family support programs and 265 matched controls. Surveys measured treatment outcomes in level of depression, perceived social support, knowledge of child development, and punitive attitudes toward parenting. Although offering a diverse array of services, each program had a drop-in center for parents and offered parent education and support classes. Two of the sites also offered a home visitors program. Results revealed little relationship between the receipt of family support services and treatment outcome measures.

McBride (1991) examined the impact of parent education and support programs on paternal involvement and perceptions of parental competence for fathers. Participants included fathers and their preschool aged children ($N = 60$) who volunteered to take part in the program. A "wait-list" control group technique was used to assign subjects to two treatment groups and two control groups. Those in the treatment group participated in one of two parent education/play group programs each having the major components of group discussions and father-child play time. Pretest and posttest data were gathered from all participants. Results revealed that participation in the program had a significant positive effect on the fathers' perceptions of parental competence and in parental involvement in the areas of interaction and accessibility, particularly on non-workdays.

In a review of empirical studies examining the outcomes of family support programs serving low-income families, Weiss and Halpern (cited in Allen, Brown, and Finlay, 1992) reported that 13 of the 19 studies included in the review indicated short-term improvements in one or more areas of maternal behavior, including parent-child interaction, parent responsiveness, and parents' understanding of how to encourage their child's development. Additionally, for those studies including data on parents' general coping abilities and personal development, many of the studies reported positive effects. Studies documented generally positive effects on infants' and young children's performance on developmental tests.

The next several paragraphs describe the evaluation results of six family support programs included in a report by Allen, Brown, and Finlay (1992). Four pilot Parents as Teachers (PAT) programs in Missouri were initiated in 1981, and in 1984 the programs were implemented on a statewide basis. The programs operate through the public school system and strive to "give children the best possible start in life and prepare them for school success by supporting parents in their role as children's first and most important teachers" (Allen, Brown, & Finlay, 1992, p. 48). Services are provided to families until the child reaches the age of three, at which time home visits terminate. However, some families continue to be involved in other available activities until their child reaches kindergarten. The programs are comprised of four main components, including home visits, group meetings for parents, regular monitoring of children's health and developmental status, and referral to social service and other agencies when necessary. In 1985, an evaluation of the four pilot programs revealed promising results. In this pilot study, the 3-year-old children who had been involved in the program since birth were significantly more advanced than the comparison group in language development, problem solving skills and other intellectual abilities, and in the display of coping skills and positive child-adult relationships. Results revealed that children evaluated at the end of their first-grade year were doing better in school than children in the comparison group, and their parents displayed greater involvement in the education of their children. Further, teachers reported that children in the PAT program were better prepared for school than most other children in similar families. A 1991 evaluation of the statewide program revealed that the benefits of PAT had been sustained over time. In general, parents experienced improved coping skills, an increase in their knowledge of child development, and an enhanced ability to communicate in an effective manner with their children. Further, the children performed significantly above national norms on achievement, and greater than half of the children with developmental delays had overcome them by age 3.

The Center for the Development of Nonformal Education (CEDIN) is a family support program which seeks to promote and strengthen families by offering training opportunities in prenatal, early childhood, and parenting education. Services are community-based, family-centered, and culturally comprehensive in nature. The primary aspect of the Center is the home-based Parent-Child Program which instructs parents in the use of various methods for preventing or reversing developmental delays in their infants and toddlers. A 3-year evaluation (Allen, Brown, & Finlay, 1992) of the CEDIN program revealed positive effects for the children in the areas of health and development. At age 2, the children in the CEDIN program were slightly more advanced in their mental development than those in a comparison group. These children also experienced fewer hospitalizations as they aged, possibly due to the emphasis on health education. Further, program participants improved in the areas of discipline methods and the safety and appearance of their living environment.

The Parent Services Project (PSP) evolved as a result of the expansion of child care centers to offer services and support to the entire family. The primary goals of the PSP are to increase the parents' sense of self-worth, to decrease feelings of isolation, to improve parenting skills, and to assist parents in locating support resources in the community. Available activities include parenting classes, peer support groups, mental health workshops, opportunities for socialization, special groups and activities for fathers, respite child care on weekends, and emergency home-based child care services. During 1985-1988, an evaluation (see Allen, Brown, & Finlay, 1992) of the PSP revealed that as compared to those in a control group, parents participating in the project experienced significantly lower levels of stress, maintained lower stress levels, and had higher self-esteem. Further, these parents experienced an improvement in their attitudes about childrearing and interactions with their children.

Friends of the Family is an independent agency which oversees a statewide network of family support centers in the state of Maryland. The centers were established to address the problem of high rates of teen pregnancy and an increasing incidence of child abuse and neglect. Programs varied from area to area to meet the needs of the local community; however, *all* programs provided a range of social support services and assistance in child development. General Equivalency Diploma (GED) preparation courses and parenting classes also were offered. In 1988, a total of eight Friends of the Family support centers existed in the state. An evaluation of these programs revealed that the centers were reaching their goal of serving high-risk families. The researchers concluded that "the programs were contributing to a reduced likelihood of repeat pregnancies, clear educational advances by participating mothers, and enhanced family stability" (Allen, Brown, & Finlay, 1992, p. 66).

The Maternal Infant Health Outreach Worker Project (MIHOW), a network of family support programs, was established in 1982 to serve rural families in the Mississippi Delta and Appalachian region. The goals of the MIHOW project are to improve prenatal and infant care and to enhance the development of human resources in the region. Outreach services constitute the primary activity of these family support programs. Outreach workers visit families' homes to assist with health and childrearing problems and to link families with other resources in the community. Early evaluations of the efficacy of the MIHOW programs indicated that maternal health care practices during pregnancy and infant feeding practices were improved, and that mothers were more responsive to their children, provided more appropriate play materials, and were more involved in promoting the achievement of age-appropriate skills in their children than before participation in the program. More recent evaluations have incorporated the use of focus groups and in-depth interviews with parents and staff. These evaluations have demonstrated the positive effects of the programs, in that, parents reported having more hope for the future, more control over their own lives, and an increased ability to advocate for their children (see Allen, Brown, & Finlay, 1992).

The Ewa Healthy Start Program at Ewa Beach in Hawaii began in 1985 and was used as a model for the state-funded Healthy Start/Family Support Services program established in 1988. The purpose of the program is to develop a strategy to prevent juvenile delinquency and other problems associated with an abusive, disadvantaged childhood. Families of newborns are screened for family risk factors, and those with a substantial number participate in the program. Families receive weekly visits from a family support worker who links the family with a pediatrician and assists the family in coping with crisis situations, for example, aids the family in obtaining housing assistance. Home visits also provide support for improved parent-child relationships, increased knowledge of child development, and enhanced parenting skills. Child development specialists are available to assist the families of children with special needs. A 3-year evaluation of the Ewa demonstration project revealed positive effects of the program (see Allen, Brown, & Finley, 1992). The program appeared to be successful in identifying families at high risk of child abuse or neglect and was successful in the prevention of abuse and neglect. For a total of 241 at-risk families, child abuse was averted in 100% of the cases, and neglect occurred in four cases. For families identified as high risk but not served because of a lack of resources, the rate of abuse was three times higher than in the general population. For nine of the Healthy Start/Family Support Services programs in Hawaii, outcomes were positive, as abuse and neglect each were averted in over 99% of the cases.

Family Support and Self-Help Groups

As is evident from the previous descriptions, the concept of family support encompasses a wide array of possible services. Family support and self-help groups represent only one of the possible components which comprise family support services. In the system of care model proposed by Stroul and Friedman (1986), self-help and support groups fall under the rubric of operational services, defined as a range of support services that "cross the boundaries between different types of services" and play a critical role in the "overall effective operation of the system" (p. 93).

There appears to be wide variation in the membership, format, and duration of parent support groups; however, most share common characteristics (Koroloff & Friesen, 1991). Usually, 4 to 20 parents meet on a regular basis to discuss the problems and issues associated with parenting a child with emotional disturbance and to provide mutual encouragement and suggestions for dealing with problematic situations. Groups may serve as an information resource, an opportunity to promote the importance of legal and legislative action on behalf of children, and a chance for families who are experiencing similar situations or conditions to share common concerns and provide mutual support. Further, groups may be informal or formal in nature; that is, "they may be formally constituted and affiliated with larger formal organizations or may involve relatively informal meetings of a small number of family members" (Koroloff & Friesen, 1991, p. 267).

The needs of families of children with serious emotional disturbances vary; however, emotional support appears to be a common component. In fact, in a national study of parents whose children have serious emotional disorders, Friesen (1990) found that 72% indicated that "emotional support" was the activity that was most helpful in coping with the difficulties associated with raising their child. Thus, for the purposes of this review, research pertaining to the effectiveness of family support and self-help groups has been included.

Effectiveness and Outcome Research: *Family Support and Self-Help Groups for Families of Children with Serious Emotional Disturbances*

Although a small number of support groups for parents of children with emotional disorders have been in existence for a number of years, research on the effectiveness and outcomes of these groups is scarce. A review of the literature conducted by Koroloff and Friesen (1991) revealed no studies which specifically addressed the effectiveness of support groups for parents of children with emotional disabilities. Although a limited amount of research is available in this area, there exists a widespread belief that participation in parent support groups leads to beneficial outcomes for members. Some of these benefits have been identified as the receipt of (1) information about the disorder and available services, (2) advocacy information, (3) problem-solving skills, (4) emotional support, (5) reduced isolation, and (6) assistance with coping (Gartner cited in Koroloff & Friesen, 1991). These benefits of participation in support groups have been described in the literature (see Koroloff & Friesen, 1991, for a brief review). In the following section, a description of the available literature on the benefits of self-help and support groups for families of children with serious emotional or behavioral problems is presented.

Lutzer (1987) described the structure and functioning of a four-session educational and peer support group for mothers of preschool children at-risk for behavioral disorders. Participants in the study were self-referred mothers who appeared socially isolated, were relatively unaware of the stages of normal child development, and described the behavior of their children as abnormal. Mothers received information on normal development and behavior modification techniques as well as peer support exercises designed to enhance skills for stress reduction, assertiveness training, and reflective listening. Measures of evaluation included attendance records, degree of participation, and written and verbal feedback. Results revealed that attendance rates were strong for the first two series of sessions with some attrition from the first to the fourth session. The third and fourth series of sessions reported attrition rates of 50% and 40%, respectively. With regard to degree of participation in group discussions, the author reported that all mothers frequently made eager and assertive contributions. Discussions generally were goal-oriented and rarely deviated from the topic at hand. Comments were unanimously positive in nature, and participants reported being pleased with their child's participation in the child care group. Final evaluation forms indicated that participants (1) were interested in a longer series with longer sessions, (2) expressed a sense of pleasure in feeling understood by the leaders and other participants, (3) expressed a desire to continue in these interactions in later classes, (4) experienced increased feelings of positive self-esteem, and (5) communicated an awareness of the normalcy of themselves and their children. The authors concluded that this group format as compared to therapeutic models offered a relatively short and inexpensive method for altering maternal attitudes and behaviors.

In a study involving 834 parents of children with emotional disabilities, a written questionnaire was distributed to compare parents who participated in parent support groups with nonmembers across a number of variables (Koroloff &

Friesen, 1991). Results revealed no significant differences between members and nonmembers on most demographic variables; however, members of support groups reported that they needed and used more information and services than nonmembers but found these more difficult to locate. Most importantly, 31% of all respondents identified involvement with other parents of children with serious emotional disturbance as the most helpful activity in increasing their ability to cope with raising their child.

Sheridan and Moore (1991) reported the results of a six-session educational and support group for parents of adolescents with schizophrenia. The goals of the group were to increase parents' level of knowledge about schizophrenia and to provide group support to decrease the parents' sense of isolation. Two questionnaires, designed to assess the impact of the illness on group members as well as parents' level of knowledge about the disorder, were administered during the initial group session. At the termination of the group, a third questionnaire was administered to obtain feedback on the group process. The responses of 29 parents from two groups were used in the analysis. With regard to the impact of the disorder on the family, results indicated that the areas most affected were relaxation time and the ability to concentrate on work at home or in a job. In general, participants, and especially mothers, indicated that they worried too much. Further, results indicated that attitudes regarding discipline had changed with regard to their child with schizophrenia. Most participants related that their family was open and able to discuss feelings, with feelings of worry and sadness being the most difficult to express and feelings of anger and happiness the least difficult to express. No significant difference in pretest and posttest scores was evident for parents' level of knowledge about schizophrenia. This may be attributed to the fact that parents scored very high on the pretest measure and thus, had little room for improvement. Feedback on the support group indicated that support from other parents in similar situations was the aspect most valued by the participants. The impression of the clinical team was that participation in the group and confidence in a group setting was "matched" by gains in the parents' ability to manage their children's behavior in the home. The team also reported the receipt of fewer crisis telephone calls from parents during and following participation in the group.

Family Support Services & Support Groups

Dreier and Lewis (1991) presented the results of the evaluation of an open-ended group for parents of children hospitalized for mental illness. The group model consisted of a combination of the support and psychoeducational group models. The goals of the group were to assist parents in feeling less apprehensive about the hospitalization of their child and to decrease feelings of failure in their parenting role. Outcome evaluation was based on staff observations of parent-child interaction and anecdotal reports from parents. Parents reported that they experienced more positive feelings about themselves and their ability to understand and interact more competently with their children. The authors concluded that the group model served as "a viable treatment method in helping parents cope with their children's severe behavior disorders" (p. 17).

The Parents Involved Network (PIN), a self-help, advocacy, information and training resource, was established "to provide a vehicle through which parents of children with serious emotional problems can raise their concerns and voice their collective priorities" (Corp & Kosinski, 1991, p. 241). In a study conducted to investigate the outcomes of parent involvement in support group and advocacy training activities, Fine and Borden (1992) found that participation in the self-help group met parents' support needs, and participation in training activities allowed them to become more effective advocates for their children. The parents' perceptions of the changes in their lives as a result of their participation in the support group revealed two significant outcomes. The first was a change in their reactions to a crisis situation. That is, during a crisis, parents continued to attend group meetings and to interact in an effective manner with other parents by giving and receiving support. A second outcome involved an increase in self-esteem. While initially these parents perceived themselves as failures and poor parents, involvement with PIN resulted in a greater sense of control and self-assurance, thus decreasing feelings of guilt and blame for their child's difficulties. Further, the majority (72%) of parents that were followed continued to have some form of interaction with PIN, and 44% of these parents were involved in either support group activities or advocacy efforts on a regular basis. In another review of PIN, Corp and Kosinski (1991) found that parents who were in contact with parent groups on a frequent basis were able to gain more desirable and effective services for their children and reported a marked reduction in feelings of isolation, guilt, and anger.

Moynihan, Forward, and Stolbach (1994) reported the results of a consumer satisfaction survey of 96 parents of children and adolescents with severe mental disturbance in Colorado. Although not designed to measure client outcome, the consumer satisfaction surveys provided valuable information about the concerns and needs of families. In the area of parent support/self-help groups, 36% of those surveyed indicated that they had participated in a parent support or self-help group. Of these, 70% indicated that the group was an effective vehicle for meeting their needs. The remaining parents indicated that they were unsure or did not believe that participation in a support group met their needs. Further, of those who had participated or desired participation, the majority (61%) reported that they felt that the group should be composed of parents and professionals, while 17% indicated that the groups should include parents, professionals, and children. A very small percentage (4%) indicated that only parents should participate.

Effectiveness and Outcome Research: *Self-help and Support Groups for Families of Children with Other Disabilities*

Due to the scarcity of literature on self-help and support groups for families of children with serious emotional disturbances, it is helpful to draw from the recent (1985 to present) literature on self-help and support groups for the families of children with other special needs, such as physical or developmental disabilities, as this information is more readily available. As a result of the literature search, nine studies which examined support groups for families of children with a variety of special needs were revealed, each investigating different outcomes. A brief overview of these studies is presented.

In 1985, Hinrichsen, Revenson, and Shinn conducted an empirical investigation of peer support groups for individuals with scoliosis and their families. Psychosocial and satisfaction with services data were obtained from survey questionnaires in a cross-sectional study of adults with scoliosis and adolescents with scoliosis and their parents, each of whom were members of a self-help organization for persons with scoliosis (*n* = 245). Nonparticipants who had expressed an interest in scoliosis groups (*n* = 495) served as a comparison group. Data revealed that although most participants reported a high degree of satisfaction with the group, participation had little effect on psychosocial outcomes. Participation seemed to be most helpful for adult patients, particularly those who had endured the most intensive medical treatment.

Krauss, Upshur, Shonkoff, and Hauser-Cram (1993) examined the impact of participation in parent groups on mothers of infants with disabilities (*N* = 150). Results revealed that intensity of participation was associated with both positive and negative outcomes in the areas of maternal functioning and social support. That is, participation in the parent group was associated with significant increases in the size and helpfulness of social support networks, while increased group attendance was related to increased levels of personal strain and greater adverse effects on familial/social relationships.

Moran (1985) evaluated the impact of participation in an early intervention program on mothers (*N* = 85) of children with disabilities. Findings indicated that in comparison to nonparticipants, mothers in the program reported less intensive levels of stress; however, no differences in an increase in informal support networks were noted.

A study involving mothers (*N* = 56) of children with special needs was conducted by Shapiro (1989). Interview data revealed that those who participated in support groups (*n* = 34) were less depressed, perceived their child as less burdensome, and employed more problem-solving coping strategies than mothers who did not participate in support groups (*n* = 22).

In an evaluation of a bi-monthly group program for fathers of children with disabilities, Vadasy, Fewell, Meyer, and Greenberg (1985) found lower levels of stress and depression and a higher degree of satisfaction for both parents following the fathers' group participation for a period of one year. Follow-up results revealed that the effects were maintained over time; however, fathers reported a higher degree of pessimism over time (Vadasy, Fewell, Greenberg, Dermond, & Meyer, 1986).

McLinden, Miller, and Deprey (1991) examined the effects of a 6-week support group for siblings (*n* = 6) of children with special needs. Pretest and posttest assessments revealed that the support group had a significant positive effect on perceptions of social support for participants as compared to those in the control group ($n = 5$). No significant differences were noted on outcome measures assessing behavior problems, self-concept, or knowledge and attitudes. Parental interview data revealed some improvements in participants' behavior toward siblings.

In a similar study, Lobato (1985) examined the effects of a 6-week workshop for preschool-age siblings of children with handicaps ($n = 6$). Data were collected from clinic role-play assessments and direct observation of sibling interactions conducted at home by parents. Participants' knowledge of factual information of developmental disabilities and positive verbalizations regarding family members and themselves were found to increase, while the number of negative verbalizations decreased.

James and Egel (1986) investigated the impact of direct prompting and modeling procedures on the interactions between nonhandicapped children ($n = 3$) and their preschool-age handicapped siblings involved in a play group. Results revealed that the intervention was effective in increasing positive reciprocal interactions between the siblings, and that these positive interactions generalized to larger playgroups across settings. Six-month follow-up data revealed that positive behaviors were maintained over time.

Conclusions and Future Research Needs

As families have begun to enter into partnerships with professionals in planning the treatment of their children with special needs, there has been an increasing recognition of the need for supportive services for families. A number of family support services and programs have been developed in recent years to meet the needs of these families. Family support programs can cater to families of children with a wide variety of special needs and provide a broad array of services which may include self-help, support, and advocacy groups; information and referral sources; educational and training opportunities; respite care; and cash assistance or assistance with the acquisition of basic needs. This review examined the available literature base on the effectiveness of family support services as well as outcomes associated with participation in self-help and support groups.

Family Support Services & Support Groups

Evaluation findings associated with family support services revealed generally positive results for both parents and children; however, at least one study reported a relationship between the receipt of family support services and measures of parenting (see Reis, Bennett, Orme, & Herz, 1989). Many of the evaluations included in this review revealed that parents who received family support services generally were satisfied with services received; experienced a significant reduction in stress and social isolation; held a more positive view of their child's behavior; displayed an increase in parental competence, parent-child communication skills, and parent-child involvement, coping abilities, knowledge of child development, parenting and advocacy skills; and exhibited a decrease in the occurrence of child abuse and neglect.

A few evaluations investigated the impact of family support services on the children. For instance, a review of research studies which examined outcomes of family support programs serving low-income families found that, in general, services had a positive impact on the performance of infants and young children on developmental tests. Evaluations of the PAT and CEDIN programs revealed a positive impact of family support services on children's level of achievement, health, and mental development.

Evaluations of the benefits associated with participation in self-help and support groups also have shown generally positive results. The evaluations included in this review revealed a variety of outcomes related to participation in self-help and support groups. These findings included an increase in feelings of emotional and social support, self-esteem, knowledge of child development, ability to manage child's behavior, use of problem-solving coping strategies, and ability to interact positively with their children. Further, findings indicated fewer crisis situations, decreased levels of stress, and less depression. One study revealed little effect of participation on psychosocial functioning, and another found no difference in increase of informal support network between treatment and comparison groups. Yet another found both positive and negative outcomes in the areas of maternal functioning and social support.

Studies examining the effects of self-help and support group participation for siblings of children with special needs resulted in mixed findings. Most findings indicated an increase in the siblings perception of social support, more positive interactions between siblings, an increase in positive verbalizations about self and family members, and increased knowledge of their siblings' special needs; however, one study found no significant differences between participants and nonparticipants on measures of behavioral problems, self-concept, or knowledge and attitudes.

As the movement toward family-centered care continues, parents are taking on a variety of alternative roles. According to Friesen and Koroloff (1990), one of the most significant factors in augmenting the role of parents is the formation of an organized and distinct "parent voice" (p. 19). Advocacy is one of the most important roles in which parents engage. In fact, an increase in the advocacy movement has been proposed as one of the major challenges of the 1990s (Duchnowski & Friedman, 1990). Historically, the parents of children with serious emotional disturbances have not been "an organized advocacy force" (Friesen & Huff, 1990, p. 32); however, in recent years a number of positive developments in this area have occurred (see Duchnowski & Friedman, 1990; Friedman, Duchnowski, & Henderson, 1989), including the establishment of the Federation of Families for Children's Mental Health, a national parent-run organization which strives to improve services for children with serious emotional disturbances and their families. Another significant development was the occurrence of the "Families as Allies" conferences. Beginning in 1986, these conferences were held in every region of the country to allow parents and professionals to form partnerships and to identify parents of children with serious emotional disturbance who were interested in forming support groups. As a result of these conferences and other similar efforts, a number of statewide parent advocacy organizations and local support groups were developed to help parents "organize for the purposes of support, education, and advocacy" (Friesen & Koroloff, 1990, p. 19). Further, a number of national organizations have begun to focus on the needs of children, e.g., the National Mental Health Association, National Alliance for the Mentally Ill, Children's Defense Fund, the Child Welfare League of America, and the Association of Child Advocates. A more recent development has been the availability of statewide family network demonstration grants funded by the Center for Mental Health Services. Grants are to be used for the establishment or enhancement of statewide, family-controlled networks to provide support and information to families of children with serious emotional, behavioral, or mental disorders.

Koroloff, Elliott, Koren, and Friesen (in press) provided a description of yet another alternative role for parents. Based on the principles of parent-to-parent support, the Family Connections Project has implemented Family Associates in three counties in Oregon. The Family Associate is "a parent without professional mental health training who acts as a system guide to low-income families whose children have been referred to mental health services through EPSDT" (p. 2). The Family Associate provides emotional support, services and referral information, and assistance with transportation and child care. The role of the Family Associate is to assist families in overcoming barriers that may inhibit access to mental health services. An evaluation of the effectiveness of the use of the Family Associate is planned.

The emerging role of families as full participants in the treatment planning process for their children with special needs has resulted in the development of a variety of family support programs and services. In general, these services have had a positive impact on a number of life domains, e.g., less stress and improved parenting skills. Furthermore, the development of family support and self-help groups have resulted in positive outcomes. The parents of children with emotional disorders contend with a variety of parenting issues. Support and self-help groups allow families to provide mutual support as they endure the hardships associated with their parenting role. Families also have taken on alternative roles such as advocacy partners with professionals or Family Associates as described in the Family Connections Project. As families continue to take on an increasingly significant role in the treatment planning process for their children with emotional and behavioral problems, it is likewise important that researchers begin to involve families in the research planning process. The research contained in this review points to a number of possible research directions. First, the importance of conducting further research to better document the needs of these families is evident. Second, research must focus on how to involve families more fully in the treatment planning process for their children and how to support them more adequately in their role as "allies" in this process. Third, additional research must ascertain more completely the effects of participation in self-help and support groups for families, parents, and siblings. Finally, additional information is needed about *which* group approaches and models (e.g., psychoeducational or support) work most effectively with *which* families.

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Chapter Eight

Summary and Conclusion

Adolescent mental health is an often neglected area of research (Kazdin, 1993). However, research in the area of children's mental health services has received increased attention in recent years. Since the review by Burns and Friedman (1990), the research base examining the effectiveness of the components within a system of care has expanded considerably. The purpose of this series of reviews was to give readers an overview of this emerging research base and to provide impetus for possible areas and directions for future research. The information contained in this series of reviews focused on the following eight service components in a system of care: residential services, outpatient (psychotherapy), day treatment, family preservation, therapeutic foster care, crisis and emergency, case management/individualized care, and family support. A brief overview of the research on each component is described in the following paragraphs.

Studies investigating the outcomes and efficacy of residential services, i.e., psychiatric hospitals and residential treatment centers, vary widely in focus and

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methodology. The majority of research studies presented in the current review did not examine residential care in comparison to other service approaches, but rather focused on factors relating to outcome. Factors found to be predictive of positive outcome included adequate intelligence; nonpsychotic, nonorganic diagnoses; the absence of bizarre and antisocial behaviors; healthy family functioning; adequate length of stay; adequate aftercare; and the presence of a standardized treatment regimen (see Blotcky, Dimperio, & Gossett, 1984; Pfeiffer & Strzelecki, 1990). Hoagwood and Cunningham (1992) found that shorter lengths of stay were associated with positive outcome. Factors found to be predictive of poor outcome included a diagnosis of Attention Deficit-Hyperactivity Disorder (ADHD), poor initial response to treatment, older age at admission, child depression or sadness, presence of neurological or psychotic symptoms, limited after care services, history of physical abuse, and higher intellectual functioning (Blumberg, 1992; Kalko, 1992). Studies which compared residential treatment services to no-treatment groups found that, in general, youth receiving residential services experienced more positive outcomes than youth who received no services. Despite a lack of rigorously controlled studies and the wide variability among the features of the residential treatment programs included in the review, the research appears to indicate that residential treatment has resulted in improved functioning for some children. However, further research is needed to determine which youth can most benefit from this type of treatment as well as those treatment approaches which work best with specific populations of children and youth.

In general, most laboratory-based studies examining the effectiveness of psychotherapy for children found an overall positive effect of treatment. However, it has been argued that these laboratory-based studies fail to accurately represent how therapy and treatment are carried out in "real world" clinic-based settings (Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz, 1988; Weisz, Donenberg, Han, & Kauneckis, in press). In fact, the clinic-based studies reviewed by Weisz and his colleagues seemed to indicate that the effects of psychotherapy are not as positive as the findings reported by the meta-analyses of research-based studies. Thus, more research on the effectiveness of psychotherapy in clinic-based settings is needed.

Summary and Conclusion

Based on the present literature review, it appears that the features of day treatment programs vary widely in regard to treatment setting, populations served, treatment approaches, theoretical orientations, and program components. Although this variation minimizes our ability to draw conclusive statements concerning effectiveness, three *tentative* conclusions appear to be suggested in the research contained in the present review. First, the family plays a significant role in the child's outcomes following day treatment services. Secondly, day treatment services may be effective for a limited population of children. That is, most studies found that treatment gains were less likely for children with severe behavior problems than for children with other disabilities. Finally, based on a small number of studies, evidence seemed to suggest that treatment gains apparent in the home did not generalize to the school setting. Thus, it appears that day treatment services are a promising and cost-effective approach in the treatment of *some* children and youth with emotional problems.

From the studies reviewed, it appears there is research support for the effectiveness of family preservation services. It was estimated that about 70% to 96% of the children remained with their families at service termination. While it appears that many family preservation programs have proven effective in keeping families intact and preventing or delaying the placement of children, the effects do not appear to be long lasting, and families continue to be at-risk following service termination. That is, treatment gains appear to decrease as the amount of time following discharge increases. Although these findings appear to support the efficacy of family preservation services, concerns have been raised about these studies, including the use of a single outcome criteria (i.e., rate of placement prevention) and the ambiguity associated with the use of placement as an indicator of treatment failure (Wells & Whittington, 1993). Further, Usher (1993) asserts that imprecise targeting of admissions to family preservation programs and inconsistency in service delivery are problematic issues in the evaluation of effectiveness. Therefore, while there is empirical support for family preservation services this evidence must be viewed with caution due to these concerns.

Therapeutic foster care services are a relatively new form of treatment for children with serious emotional disorders and their families. The majority of studies

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examined discharge rates as the sole outcome criterion with rates ranging from 62% to 89%. That is, between 62% and 89% of the children who received therapeutic foster care services were placed in less restrictive settings upon discharge. Studies examining other outcomes (e.g., child functioning, time spent in family-based settings, rates of incarceration and arrests, behavioral and emotional adjustment, academic performance, and birth family interactions) generally have reported positive results. Most evaluations have pointed to the general effectiveness of therapeutic foster care; however, the need for more specific areas of research have been suggested in the literature. These future research directions include determining for which populations this service works best, comparing the effectiveness of therapeutic foster care to other service components, investigating the impact of therapeutic foster care across multiple dimensions, determining the variables necessary to produce successful outcomes, and examining the long-term effects of this service.

Because of the nature of crisis and emergency services, most programs have not included a formal evaluation component. Thus, few studies or evaluations examining the effectiveness of crisis and emergency services were available in the literature. Most evaluations examined out-of-home placement prevention rates or the percentage of reduction in admissions to residential settings as outcome criteria. For those studies included in this review, placement prevention rates ranged from 60% to 90%. An extensive study examining individual and family functioning and behavioral indicators revealed that children experienced fewer behavioral problems during treatment and follow-up. Further, the child's adaptive behavior and family and marital functioning improved during follow-up. While the literature regarding the effectiveness of crisis services continues to develop, initial results appear to support the expansion of such services. Future research which evaluates the effectiveness of crisis services across multiple dimensions as well as in comparison to other treatment approaches is needed.

Due to the difficulty in evaluating the separate contribution of case management services to the overall effectiveness of a system of care, there is a virtual absence of well-controlled studies in the field of children's mental health. Despite this difficulty, recent efforts have been undertaken in New York to examine the effectiveness of case management services for this population. Findings regarding effectiveness were mixed. One study found that the provision of case management services was associated with fewer hospitalizations, fewer days spent in the hospital, and more days spent in the community. A second study compared the effectiveness of two intensive community-based programs. One program which implemented intensive case management services (Family-Centered Intensive Case Management Services; FCICM) was compared to a program in which no intensive case management services were delivered (Family-Based Treatment Foster Care; FBT). Six-month preliminary data revealed no dramatic change or differences across the two interventions in the areas of service needs, family functioning, and child symptomatology. For other populations of children, e.g., children with developmental disabilities and chronic health conditions, homeless children and youth, at-risk children and youth, and youth with substance abuse problems, case management services generally have been found to result in positive outcomes.

The closely related area of individualized care also suffers from a scarcity of efficacy literature. The results of programs incorporating the principle of individualized care for children and youth with serious emotional disorders have revealed mixed results. Evaluations of the Willie M. Program in the State of North Carolina did not provide strong support for the reduction of risk of later arrest among violent and assaultive youth following participation in the program. In contrast, a qualitative analysis of 10 youth who participated in the Alaska Youth Initiative (AYI) revealed that the provision of individualized care was effective in serving as an alternative to restrictive residential treatment for a sample of the most challenging youth in Alaska. Findings from an evaluation of Project Wraparound in Vermont indicated the effectiveness of the program in improving child and family functioning in the home setting; however, behavioral improvements did not generalize to the school setting. Based on the limited research available, it appears that the provision of case management and individualized care services are promising approaches for meeting the complex needs of a portion of children and youth with serious emotional disorders and their families; however, further research is greatly needed to identify those models that are most effective in meeting the needs of this population.

The review of family support services uncovered few evaluations of programs methodology. The majority of research studies presented in the current review did not examine residential care in comparison to other service approaches, but rather focused on factors relating to outcome. Factors found to be predictive of positive outcome included adequate intelligence; nonpsychotic, nonorganic diagnoses; the absence of bizarre and antisocial behaviors; healthy family functioning; adequate length of stay; adequate aftercare; and the presence of a standardized treatment regimen (see Blotcky, Dimperio, & Gossett, 1984; Pfeiffer & Strzelecki, 1990). Hoagwood and Cunningham (1992) found that shorter lengths of stay were associated with positive outcome. Factors found to be predictive of poor outcome included a diagnosis of Attention Deficit-Hyperactivity Disorder (ADHD), poor initial response to treatment, older age at admission, child depression or sadness, presence of neurological or psychotic symptoms, limited after care services, history of physical abuse, and higher intellectual functioning (Blumberg, 1992; Kalko, 1992). Studies which compared residential treatment services to no-treatment groups found that, in general, youth receiving residential services experienced more positive outcomes than youth who received no services. Despite a lack of rigorously controlled studies and the wide variability among the features of the residential treatment programs included in the review, the research appears to indicate that residential treatment has resulted in improved functioning for some children. However, further research is needed to determine which youth can most benefit from this type of treatment as well as those treatment approaches which work best with specific populations of children and youth.

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treatment planning process for their children, and to determine how to better support families in their role as "allies" (Friedman, Duchnowski, & Henderson, 1989).

Systems Research

Along with the importance of examining the effectiveness of the service components within a system of care, it also is necessary to conduct research which focuses on the system of care as a unit of analysis (Burns & Friedman, 1990). Because the components of a system of care are interrelated, the efficacy of an individual component may differ when placed within a system containing other components. For example, the positive long-term effects of residential services may be increased if day treatment services are available as an aftercare service.

Evaluation and research in children's mental health services have only recently incorporated a systems approach (Morrisey, 1992). As treatment for severe emotional disorders in the 1960s moved to the community, so did evaluation and research activities on service delivery. The historic model that included the examination of unitary dimensions of treatment on specific disorders, such as the effects of social skills training on antisocial personality disorders, is being replaced with complex models of interactions between community, service delivery systems, and the family.

There are four salient domains that set or underscore the context for systems of care research, see Figure 1 (Friedman, 1994). The first context includes going beyond the mental health service delivery system and integrating other systems such as juvenile justice, child welfare, and education into services and research designs. This would necessitate extending beyond measures of emotional and behavioral adjustment and including multiple areas of functioning, i.e., the educational and social areas. This also implies obtaining multiple perspectives from service providers, parents, teachers, and the children themselves about services and their effects.

The next context for system of care research is a very broadly defined target population. The federal definition for children with a serious emotional disturbance, published by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (1993), is as follows: "Persons from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within *DSM-III-R* (or the most recent edition of *DSM*) that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities" (p. 29425). This broad-based definition of impairment is difficult to define, and the development of instruments to measure impairment is in its infancy.

Another important context for system of care research is that children and families move through a complex array of individual services provided by multiple agencies. This movement may differ for each child and family depending upon individual needs. Because of this increased complexity, current program evaluation differs from traditional program evaluations which, for example, examined pre- and post-test measures when a child was placed in a program for a 30-day period. Currently, program evaluations are conducted on a complex service system.

The final context for systems of care research is the community in which services are delivered. Community descriptions should go beyond the geographic and demographic descriptions that are commonly used and take into account the strengths, problems, natural supports, values, norms, and social and political structures within a community. For example, communities may differ in values and help-seeking behaviors, and these differences can affect a community's responsiveness to interventions and the manner in which interventions should be structured.

Figure 1.

Context Affecting Development and Research on Systems of Care

- ***Involvement of all child serving agencies and systems.***
- ***A focus on functional impairment as well as diagnosis.***
- ***Service delivery is movement through an individualized array of services.***
- ***Community characteristics and beliefs.***

There also are three outcome domains or dependent variables that are examined in systems of care research. These domains are as follows:

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- *Access and Utilization of Services.* Many studies focus on this single domain of describing the children and youth who use specific services. However, we know that prevalence is greater than the utilization of services. Some services are used more than others and there is differential use of services, e.g., the under-utilization of mental health services by African-Americans, for example. There are many other topics to explore in this area.
- *Costs associated with care.* Another important variable in systems of care research is the cost of service delivery. Other topics within this dependent variable are the cost of non-service or no treatment, costs of multiple service use, and cost shifting from one area to another.
- *Effectiveness or Outcomes.* The most popular and most often examined area is the effectiveness or outcomes of systems of care. This type of research examines service impact on children and families and systemic outcomes such as the number of children in out-of-home care before and after the implementation of a system of care. Other areas to explore are satisfaction with services by family members, the children themselves, and the often overlooked area of the satisfaction of service providers within systems of care.

There appear to be nine general areas of outcome that can be used in the evaluation of services to children and youth and their families: (1) emotional and behavioral functioning, (2) role performance, (3) family attachments and living arrangements, (4) safety, (5) satisfaction with life, (6) community attachments, (7) correctional activities, (8) functional skills, and (9) health. All must have a developmental approach because the skills and expectations will differ at various age levels.

To date, only a handful of studies exist which incorporate a systems approach in research on children's mental health (see Stroul, 1993 for a review of these studies). Currently, there are four efforts in this area which employ a control group. These include the California AB377 replication research on the Ventura Model (Rosenblatt, Attkisson, & Fernandez, 1992), Tennessee's AIMS Project (Glisson, 1993; Glisson & James, 1992), the West Virginia Mountain State Network Project (Rugs, Warner-Levock, Johnston, & Freedman, 1994), and the Ft. Bragg Child and Adolescent Mental Health Demonstration Project (Bickman, Heflinger, Pion, & Behar, 1992). Only the Ft. Bragg project has implemented all three outcome domains expressed by Friedman (1994).

Future Research Tasks

Research in the area of children's mental health services is in its infancy; however, the research base is beginning to expand. One important part of this expanding research base has been the examination of the effectiveness of the components within a system of care (Burns, in press; Burns & Friedman, 1990). It also is necessary to conduct effectiveness research which focuses on the system of care as a unit of analysis (Burns & Friedman, 1990).

Specific research directions for each of the service components contained in this series of reviews were noted at the end of each chapter; however, there are several general research directions that extend the research on the effectiveness of components within a system of care and on the efficacy of systems of care. One of the first areas is that of developing research surrounding the topic of cultural competence and the delivery of services which are culturally sensitive. Effectiveness research efforts should begin to include measures of the degree to which services are delivered in a culturally competent manner. Research efforts also should focus on the enhancement of educational programs within systems of care, including exceptional student education programs.

Another future research area is concerned with the need to examine the impact of a system of care on community outcomes. The examination of multiple outcome criteria, such as children's social and emotional functioning as well as the number of different living arrangements experienced by the child, have begun to be included in studies of the effectiveness of systems of care; however, future investigations may want to include community outcomes in their evaluations. For example, evaluations of systems of care could include outcome indicators such as decreased school drop-out rates within the community, decreased number of children placed in detention centers, decreased overall rates of child abuse and neglect, and greater involvement of children and families in community activities. The examination of different organizations of systems of care for different types of community configurations is another potential research direction. Systems of care models should be adapted or developed to meet the unique needs of communities. Just as the individual needs of a child and family should be met within a system of care, so should the unique needs of a community.

A great need exists to go beyond having consumers and parents participate in service delivery and research only through the completion of questionnaires dealing with satisfaction after services are delivered. Methods of participatory research for parents and consumers should be developed to ensure that they are an integral part of the service delivery, the development of systems of care, and the development of research design and its implementation.

While the research base continues to expand, so do the challenges inherent in research on child and adolescent mental health services. However, it is only through the examination of what we do know that we can begin to understand what it is that we do not know. The purpose of this review was to provide the reader with an overview of what we do know and, based on this knowledge, to provide possible avenues for future research endeavors.

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